



## New Patient Questionnaire

Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Age: \_\_\_\_\_ Father's Name: \_\_\_\_\_ Age: \_\_\_\_\_

If adults in the household work outside the home, what child care arrangements are made for this child? \_\_\_\_\_

### A. PREGNANCY AND BIRTH

1. Mother's age at birth \_\_\_\_\_
2. Did mother have any illness during pregnancy? Y N
3. Did she take any medications other than vitamins and iron? Y N
4. Was the baby on time? Y N
5. What was the birth weight? \_\_\_\_\_ lb \_\_\_\_\_ oz
6. Did the baby have any trouble starting to breathe? Y N
7. Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) Y N  
What kind? \_\_\_\_\_  
\_\_\_\_\_

### B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups until now?  
\_\_\_\_\_
2. Date of last check-up: \_\_\_\_\_
3. Date of last dental check-up: \_\_\_\_\_
4. Has your child had allergic reactions to any medications, foods, insect bites? Y N  
Which ones? \_\_\_\_\_
5. Has your child had reactions to any immunizations? Y N  
Which ones? \_\_\_\_\_
6. Any hospitalizations other than for birth? Y N  
For what? \_\_\_\_\_
7. Any serious injuries? Y N  
What kind? \_\_\_\_\_
8. Are any medications taken regularly? Y N  
Which ones? \_\_\_\_\_

### C. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Y N
2. Is it good now? Y N
3. Was there severe colic or any unusual feeding problem during the first 3 months? Y N
4. Do any foods disagree with him/her? Y N
5. For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? \_\_\_\_\_
6. If still on formula, which one? \_\_\_\_\_
7. Does he/she take vitamins? Y N

### D. REVIEW OF SYSTEMS:

1. Any ear trouble or hearing loss? Y N
2. Any eye problems? Y N
3. Has child had any problems with teeth/gums? Y N
4. Does child have frequent colds/sore throats? Y N
5. Is there asthma/pneumonia/recurrent cough? Y N
6. Does child have a heart murmur or any heart problems? Y N
7. Does child have any problems with urination? Y N
8. Does child have any problems with diarrhea or constipation? Y N
9. Have there been any convulsions or other problems with the nervous system? Y N
10. Any eczema, hives, other skin conditions? Y N
11. Has child ever been anemic? Y N
12. Please list any other medical problems:  
\_\_\_\_\_  
\_\_\_\_\_

**E. DEVELOPMENT/BEHAVIOR:**

- 1. At what age did child sit alone? \_\_\_\_\_
- 2. At what age did child walk alone? \_\_\_\_\_
- 3. Did child say any words by the time he/she was 1 1/2 years old? Y N
- 4. How does child compare to others same age?  
\_\_\_\_\_
- 5. Does child have any trouble sleeping? Y N
- 6. What grade is child in? \_\_\_\_\_
- 7. Has child had any trouble in school? Y N
- 8. Does child get along with other children? Y N
- 9. Does child have any of the following?  
 Thumb sucking                       Nail biting  
 Bed Wetting                             Bad temper  
 Problems with toilet training       Hyperactivity  
 Problems with discipline             Nightmares  
 Speech problems                         Other

**F. SAFETY/ENVIRONMENT:**

- 1. Do you live in a:  
 Private house                       Apartment  
 Mobile home                         Other: \_\_\_\_\_
- 2. Do you know the hottest temperature of the water in your pipes? Y N
- 3. Is there a working smoke alarm on each floor in the house? Y N
- 4. Does your child always use a car seat/ seat belt when riding in the car? Y N
- 5. Are there any smokers in the household? Y N
- 6. Are there any problems with the condition of your home (peeling paint, insects, rats or mice?) Y N
- 7. Does your child always wear a helmet when riding his/her bicycle or rollerblading? Y N

**G. DO YOU HAVE A RECORD OF IMMUNIZATIONS?**

Y N

**H. FAMILY HISTORY:**

(mark if present in any of your child's siblings, aunts/uncles, first cousins, or grandparents)

- Spina Bifida                               Vision/eye problems
- Bone disorder                             Cerebral Palsy
- Cleft lip/palate                          ADD/learning disorder
- Hearing loss/deafness                  Convulsions
- Heart disease/defect                  Infertility
- Neurofibromatosis                      Limb defects
- Mental retardation                      Down Syndrome
- Neurological disorder                 Cystic fibrosis
- Mental illness                          Short stature (< 5 ft)
- Tuberculosis                             Diabetes
- Hay fever/allergies                    Drug/alcohol problems
- Sickle Cell anemia                      Bleeding disorder
- Muscle disorder                         Kidney disease
- Skin disease                              Genital abnormality
- High blood pressure                  Asthma
- Urinary tract abnormality          AIDS (HIV)
- High cholesterol/triglycerides
- Chromosome abnormality
- Brain anomalies (includes Hydrocephaly)
- Anemia (includes Thalassemia)
- Patient's mother was exposed to DES
- Other birth defect/ malformations/ problems?

Please List: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

List age, sex, and health problems of brothers and sisters (are they living)? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_