New Patient Questionnaire

_____
Child's Name

_____
Mother's Name

_____
Occupation

Mother's Date of Birth_____

_____
Father's Name

_____
Occupation

Father's Date of Birth_____

_____
Childcare Arrangements

_____
Are parents: Married?
Divorced? Living Apart?
(circle one)

Pregnancy and Birth:

1.Did mom have any illness during pregnancy? No Yes

2.Did mom take any medications?
No Yes

3.Was the baby on time?
Yes No

4.What was the baby's birthweight?
_____

5.Did the baby spend time in the NICU? No Yes

Past Medical History:

1.Has child had check up in the last 12 months?	Yes	No
2.Has child had dental exam in last 12 months?	Yes	No
3.Any allergic reactions to meds, food, insects?	No	Yes
If yes, which ones?_____		
4.Any reactions to immunizations?	No	Yes
If yes, which ones?_____		
5.Any hospitalizations other than at birth?	No	Yes
6.Any serious injuries?	No	Yes
If yes, what kind?_____		

Family History:

1.Are the child's parents in good health? Yes No

2. Circle any diseases that run in the family:

Anemia	asthma	allergies
Diabetes	high blood pressure	heart disease
Tuberculosis	mental illness	drug addiction
Alcohol addiction	venereal diseases	cancer AIDS

Development/Behavior:
(don't need to answer if newborn)

1.Is development normal until now?	Yes	No
2.Any sleep problems?	No	Yes
3.What grade is child in?	_____	
4.Any trouble in school?	No	Yes
5.Does child get along with other children?	Yes	No

Safety/Environment:

1.Do you live in a: House apartment	other	
2.Do you know the water temp in pipes?	Yes	No
3.Is there a smoke alarm on each floor?	Yes	No
4.Do you always use a car seat?	Yes	No
5.Do children always ride in back seat?	Yes	No
6.Any smokers in the house?	No	Yes
7. Any guns in the house?	No	Yes
8.Any physical, verbal, or sexual abuse in house?	No	Yes

Tests/Immunizations:

1.Has child received all recommended vaccines?	Yes	No
2.Are you against vaccinating your child?	No	Yes
3.Has you child been tested for anemia?	Yes	No
4.Has your child been tested for lead exposure?	Yes	No

Review of Systems:

1.Does this child get frequent ear infections?	No	Yes
2.Any eye problems?	No	Yes
3.Any teeth problems?	No	Yes
4.Any history of asthma or recurrent cough?	No	Yes
5.Any heart murmur or problem?	No	Yes
6.Any problem with urination?	No	Yes
7.Any diarrhea or constipation?	No	Yes
8.Any history of seizures or neurologic issues?	No	Yes
9.Any eczema, hives, or other skin problems?	No	Yes
10.Any history of anemia?	No	Yes