New Patient Questionnaire

Patient's Name_______________________________________ Date of Birth________________________

HOUSEHOLD- Please list all those living in the child's home

Name	*Relationship to Child*	*Birth Date*	*Health Problems*

Are there siblings not listed? If so, please list their name and age and where they live. _______________
____

If mother & father are not living together, or if child does not live with parents, what is the child custody status. ____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? ____

Mother's Occupation ________________________ Mother's Employer ________________________

Father's Occupation _________________________ Father's Employer ________________________

Does anyone in the house use tobacco? Yes □ No□ Are there any pets in the home? Yes □ No□

Activity Level? Sedentary Active Competitive Sports

Amt of TV/Video Games daily? _____________________min/day

Uses seatbelts Car seat Booster Seat

DEVELOPMENT

Are you concerned about your child's physical development? Yes □ No□ Explain _______________

Are you concerned about your child's emotional development? Yes □ No □ Explain________________

Are you concerned about your child's attention span? Yes □ No □ Explain_________________

Is your child in school? Yes□ No □

How is his/her behavior in school? ____

Has he/she failed or repeated a grade in school? ____

How is he/she doing in academic subjects? ____

Is he/she in special resource classes? ____

New Patient Questionnaire

Birth History

Any problems during the pregnancy? Yes □ *No*□ ____

Was mom on any medications? Yes □ *No*□ *If yes* _______________________________________

Birth Hospital? ____________________________ *Birth Weight* _____________ *lbs* ______________*oz*

Was your child born: On Time Early (weeks __________) Late (weeks _________)

How was your baby born? Vaginally Delivery C-Section Vacuum Forceps

Any Problems with baby at birth? Yes □ *No*□ *If Yes* ____

Did child/children go home with mom from the hospital? Yes □ *No*□ _____________________________

Past Medical History

*When was your child's Last well- check?*____

Previous Doctor? _________________________ *Dentist?* ______________________________________

Does your child take any medications? Yes □ *No*□ ____

Any Medication Allergies? *No* □ *Yes*□ ____

Prior Hospitalization? *No* □ *Yes*□ ____

Is your son circumcised? *No* □ *Yes*□ ____

Other Prior Surgeries? *No* □ *Yes*□ ____

Has your child had a history of:

Please circle all that apply:

ADHD/ADD	*Anemia*	*Asthma*	*Bedwetting*
Cerebral Palsy	*Constipation*	*Broken Bones*	*Diabetes requiring insulin/Type 1 DM*
Developmental Delay	*Ear infections*	*Eczema*	*Food Allergies*
Headache	*Hearing Loss*	*Heart Murmur*	*Pneumonia*
Chicken Pox	*Insulin Resistance/Type II DM*	*Obesity*	*Urinary Tract Infection*
Seasonal Allergies	*Seizures*	*Sports Injury*	*Vitamin D deficiency*
Urticaria/ Hives	*Vaccine Reaction*	*Vision Problems*	*Wheezing*

*Other*____

New Patient Questionnaire

Family History

Considering the child's parents, grandparents, aunts, uncles, and siblings, is there a family history of:

Asthma? *Whom:* ____________________

Alcohol or Drug Abuse? *Whom:* ____________________

Anemia? *Whom:* ____________________

Bleeding Disorder? *Whom:* ____________________

Cancer? *Whom:* ____________________

Skin Cancer? *Whom:* ____________________

Breast Cancer? *Whom:* ____________________

Childhood or Sudden Infant Death? Whom: ____________________

Deafness? *Whom:* ____________________

Developmental Delay? *Whom:* ____________________

Diabetes? *Whom:* ____________________

Hearing problems? *Whom:* ____________________

Heart disease (before 50 years old)? Whom: ____________________

High Blood Pressure (before 50 years old)? Whom: ____________________

High Cholesterol? *Whom:* ____________________

Intellectual Disability? *Whom:* ____________________

Kidney Disease? *Whom:* ____________________

Liver Disease? *Whom:* ____________________

Mental Illness/ Depression? *Whom:* ____________________

Nasal Allergies? *Whom:* ____________________

Retinoblastoma? *Whom:* ____________________

Stroke/ Blood Clots? *Whom:* ____________________

Tuberculosis? *Whom:* ____________________

Vision Problems? *Whom:* ____________________

Patient Name: ____________________