

## NEW PATIENT QUESTIONNAIRE TO BE FILLED OUT BY PARENT

Mother's name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Father's name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

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

NAME \_\_\_\_\_

CHART# \_\_\_\_\_

DATE \_\_\_\_\_

### A. PREGNANCY AND BIRTH:

1. Mother's age at birth \_\_\_\_\_
2. Did mother have any illness during pregnancy? NO YES
3. Did she take any medications other than vitamins and iron? NO YES
4. Was the baby on time? NO YES
5. What was the birthweight? \_\_\_\_\_
6. Did the baby have any trouble starting to breathe? NO YES
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) NO YES  
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 medication, food, insects bites? NO YES
5. Has your child had a serious reactions to any immunizations? NO YES  
Which ones? \_\_\_\_\_
6. Any hospitalizations other than for birth? NO YES  
For what? \_\_\_\_\_
7. Any serious injuries? NO YES  
What kind? \_\_\_\_\_
8. Are any medications taken regularly? NO YES  
Which ones? \_\_\_\_\_

### C. FAMILY HISTORY:

1. Are child's parents both in good health? YES NO
2. Circle any diseases that this child's parents, grandparents, brothers sisters, or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex, and general health of brothers and sisters \_\_\_\_\_
4. Have any of your children died? NO YES

### D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? YES NO
2. Is it good now? YES NO
3. Was there severe colic or any unusual feeding problem during the first 3 months? NO YES
4. Do any foods disagree with him/ her? NO YES
5. For the first six months is he/she (was he/she) breast fed or bottlefed?
6. If still on formula which one do you use? \_\_\_\_\_
7. Does he/she take vitamins? YES NO

### E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? NO YES
2. Any eye problems? NO YES
3. Has he/she had any problems with teeth? NO YES
4. Does he/ she have frequent sore throats? NO YES
5. Is there asthma, pneumonia, or recurrent cough? NO YES
6. Does he/she have a heart murmur or any heart problems? NO YES
7. Any problems with urination? NO YES
8. Any problems with diarrhea or constipation? NO YES
9. Have there been any convulsions or other problems with the nervous system? NO YES
10. Any eczema, hives, or other skin condition? NO YES
11. Has your child ever been anemic? NO YES
12. Please list any other medical problems \_\_\_\_\_

### F. DEVELOPMENT / BEHAVIOR

1. At what age did your child sit alone? \_\_\_\_\_
2. At what age did he/she walk alone? \_\_\_\_\_
3. Did he/she say any words by the time he/she was 11/2 yrs old? YES NO
4. Does he/she have any trouble sleeping? NO YES
5. What grade is he/she in? \_\_\_\_\_
6. Has he/she had any trouble in school? YES NO
7. Does he/she get along with other children? YES NO
8. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others.

### G. SAFETY ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? YES NO
3. Is there a working smoke alarm on each floor in the house? YES NO
4. Does your child always use a car seat/seat belt when riding in a car? YES NO
5. Are there any smokers in the household? NO YES
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) NO YES
7. Does your child always wear a helmet when riding his/her bicycle / skates / skateboard? YES NO
8. Are there any firearms in your home? NO YES
9. Does your child have access to a pool or spa? NO YES

### H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? YES NO