New Patient Medical Questionnaire

Name of Child: _____ Today's Date:_____

Pregnancy and Birth

1. Mother's age at birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Dud she take any medications other than Vitamins and iron? No Yes
4. Was the baby on time? No Yes
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infection, other?) No Yes

_____

_____

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? No Yes
Which ones? _____
5. Is your child up to date on immunizations? No Yes
6. Has your child had any reactions to any Immunizations? No Yes
Which ones? _____
7. Any hospitalizations other than for birth? No Yes
For what? _____
8. Any serious injuries? No Yes
What kind? _____
9. Are any medications taken regularly No Yes
Which ones? _____

Family History

1. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts or uncles have had: have had the following: asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, cancer, AIDS, amblyopia, others.
2. Have any of your children died? No Yes

Feeding and Nutrition

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with your child? No Yes
5. For the first 6 months was your child breastfed or bottle fed? _____
6. If still on formula, which one?_____
7. Does your child take vitamins? No Yes

Review of Systems

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Problems with teeth? No Yes
4. Frequent colds or sore throats? No Yes
5. Asthma, pneumonia, or recurrent cough? No Yes
6. Murmur or any heart problems? No Yes
7. Problems with urination? No Yes
8. Problems with diarrhea or constipation? No Yes
9. Any convulsions or problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Has your child ever tested positive for high lead levels in the blood? No Yes
13. Please list any other medical problems_____

_____

_____

Development/Behavior

1. At what age did your child sit alone? _____
2. At what age did your child walk alone? _____
3. Did your child say any words by the time he/she was 1½? No Yes
4. How does this child compare developmentally to others his or her age? _____

_____

5. Does your child have any trouble sleeping? No Yes
6. What grade is your child in? _____
7. Has your child had any trouble in school? No Yes
8. Doeshe/she get along with other children? No Yes
9. Circle if your child has had any of the following: nail biting, thumb sucking, bedwetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others.

Safety Environment

1. Do you live in a (circle one) private house, apartment, mobile home, other_____
2. Do you know the hottest temperature of the water in your pipes? No Yes
3. Is there a working smoke alarm on each floor of the house? No Yes
4. Does your child always use a car seat/ seat belt when riding in a car? No Yes
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) No Yes
7. Does your child always wear a helmet when riding bicycle, skateboard, or scooter? No Yes