

New Patient History Questionnaire

This brief questionnaire is to make it easier for your Pediatrician to record important facts and to uncover health problems in your child. Please fill it out to the best of your knowledge. (Check or complete the appropriate box or sentence.) If you cannot answer a question, please leave it blank. Thank you for your cooperation.

Date _____
 Name _____ Age _____
 Birth Date _____
 Address _____

Telephone (Home) _____
 Work (Father) _____
 Work (Mother) _____

| | Name of: | Birth Date | Occupation | Healthy? |
|----------------------------|----------|------------|------------|----------|
| Father | _____ | _____ | _____ | _____ |
| Mother | _____ | _____ | _____ | _____ |
| Brothers & | _____ | _____ | _____ | _____ |
| Sisters | _____ | _____ | _____ | _____ |
| Others living in household | _____ | _____ | _____ | _____ |
| | _____ | _____ | _____ | _____ |

Are natural parents living together? Yes _____ No _____
 If no, please explain: _____

Birth Weight _____ Length _____

Please circle correct response:

- | | | |
|--|--------|-----------|
| Was pregnancy normal or difficult? | Normal | Difficult |
| Was delivery normal or difficult? | Normal | Difficult |
| Was the baby full term? | Yes | No |
| Did baby have any problems in nursery? | No | Yes |

Any problem during first month of life?

No

Yes

Please give details of any birth problems: _____

Development:

At what age did child:

Sit up without support _____ months

Walk alone _____ months

Talk (two words together) _____ months

Become bladder trained _____

Become bowel trained _____

If in school, present grade _____

Does the child have any school-based problems, such as failing or repeating a grade or learning problems?

Yes _____

No _____

If yes, please give details: _____

Past Medical History:

List all hospitalizations, accidents, and broken bones

| Date | Child's Age | Name of Hospital | Reason for Hospitalization/ Emergency Room Visit |
|-------|-------------|------------------|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

List major or serious illnesses.

| Date | Child's Age | Illness | Physician | Treatment |
|-------|-------------|---------|-----------|-----------|
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ |

Has the child had any of the following childhood illnesses?

| | Yes | No | Date | | Yes | No | Date |
|-------------|-------|-------|-------|---------|-------|-------|-------|
| Measles | _____ | _____ | _____ | Roseola | _____ | _____ | _____ |
| Chicken Pox | _____ | _____ | _____ | Mumps | _____ | _____ | _____ |
| | | | | Rubella | _____ | _____ | _____ |

REVIEW OF SYSTEMS

Indicate which of the following conditions or problems this child has ever had:

Give details and dates for problems checked:

- Skin trouble ()
- Eye or vision problems ()
- Eyeglasses ()
- Frequent ear infections ()
- Difficulty hearing ()
- Frequent nose bleeds ()
- Nasal allergies ()
- Sinus problems ()
- Frequent sore throats ()
- Thyroid Problems ()
- Pneumonia ()
- Asthma ()
- Any other lung problems ()
- Heart Murmur ()
- Jaundice ()
- Frequent stomach aches ()
- Frequent diarrhea ()
- Frequent constipation ()
- Black or tarry stools ()
- Kidney or Bladder infection ()
- Painful Urination ()
- Bedwetting ()
- Painful Periods ()
- Irregular Periods ()
- Vaginal discharge ()
- Joint aches or pains ()
- Orthopedic or bony problems ()
- Seizures ()
- Frequent headaches ()
- Skin rashes ()
- Eczema ()
- Reactions to Insect Bites ()
- Anemia ()
- Behavior Problems ()
- Learning Problems ()
- Speech Problems ()
- Other _____ () _____

Any allergy to food or medication?

Yes _____ No _____

If yes, please list them _____

List medications child is presently taking including vitamins & fluoride _____

Family History — Check any of the following diseases which relatives (including aunts, uncles, cousins, grandparents) have:

Eczema _____ Anemia or Blood Problems _____
Seizure Disorder _____ Alcoholism _____

| | | | |
|---|-------|---|-------|
| Tuberculosis | _____ | Kidney Disease | _____ |
| Hayfever | _____ | Cystic Fibrosis | _____ |
| Asthma | _____ | Cancer | _____ |
| High Blood Pressure | _____ | Mental Retardation | _____ |
| Heart Attack, Stroke (under 55 years of age) | _____ | Birth Defects | _____ |
| Diabetes | _____ | Psychiatric Problems | _____ |
| Obesity | _____ | Death before 50 years of age, other than accident | _____ |
| High Cholesterol or Triglycerides | _____ | | |

Please give details of diseases checked here: _____

Please list cause of death of close relatives to this child:

| Name | Relationship to Child | Cause of Death |
|-------|-----------------------|----------------|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

Psycho-Social History

What does child do in spare time? _____

Any special interests or hobbies? _____

How many hours a day does child watch TV? _____

Indicate any financial, interpersonal, or family problems you are worried about. _____

How is he/she doing in school? _____

Does he/she have good friends? _____

Does your child get easily upset? _____

Does he/she get into fights frequently? _____

Does he/she have any sleep difficulties? _____

Are you worried about your child's eating habits? _____

Present History

Are there any problems that concern you about this child now that you would like to discuss with the Pediatrician?

Reviewed by: (MD, NP, PA)
Signature

Date