

NEW PATIENT QUESTIONNAIRE

PATIENT'S NAME: _____ DATE OF BIRTH: _____ SEX: _____

YOUR NAME: _____ RELATIONSHIP TO CHILD: _____

HOME ADDRESS: _____

HOW LONG HAS THE CHILD BEEN IN YOUR CARE? _____ PHONE: _____

MOTHER'S NAME: _____ AGE: _____ OCCUPATION: _____

YEARS OF SCHOOL COMPLETED: _____

FATHER'S NAME: _____ AGE: _____ OCCUPATION: _____

YEARS OF SCHOOL COMPLETED: _____

WHO LIVES IN THE HOME WITH THE CHILD? NUMBER OF ADULTS: _____ NUMBER OF CHILDREN: _____

PLEASE LIST NAMES AND AGES OF BROTHERS AND SISTERS:

NAME: _____ AGE: _____ NAME: _____ AGE: _____

NAME: _____ AGE: _____ NAME: _____ AGE: _____

PETS: _____ TYPE OF HOME: APARTMENT MOBILE HOME HOUSE

SMOKERS IN HOUSEHOLD (INSIDE OR OUTSIDE): YES NO WHO? _____

WATER SOURCE: CITY COUNTY WELL BOTTLED

MEDICAL HISTORY

PREGNANCY HISTORY:

DID PATIENT'S MOTHER USE ANY OF THE FOLLOWING SUBSTANCES OR HAVE ANY OF THE FOLLOWING SYMPTOMS DURING PREGNANCY?

	YES	NO	DON'T KNOW	DOCTOR'S NOTES
MEDICATION (PLEASE NAME)				
STREET DRUGS (PLEASE NAME)				
ALCOHOL				
SMOKING				
VAGINAL INFECTION:				
GONORRHEA				
CHLAMYDIA				
HERPES				
GROUP B STREP INFECTION				
OTHER PROBLEMS:				

BIRTH HISTORY:

	DOCTOR'S NOTES
HOW LONG WAS THE PREGNANCY: _____ WEEKS	
PREVIOUS PREGNANCIES: TOTAL _____ MISCARRIAGES _____ STILLBIRTHS _____	
EXPLANTION OF MISCARRIAGE:	
IN WHICH HOSPITAL WAS THE BABY BORN?	
OBSTETRICIAN:	
WHAT WAS THE BABY'S BIRTH WEIGHT?	
HOW LONG DID THE BABY STAY IN THE HOSPITAL?	
WAS THE DELIVERY - VAGINAL? <input type="checkbox"/> OR C-SECTION? <input type="checkbox"/>	
DID THE BABY HAVE ANY PROBLEMS? Y <input type="checkbox"/> N <input type="checkbox"/> DON'T KNOW <input type="checkbox"/>	
DID YOUR BABY PASS THE HEARING SCREEN?	
DID YOUR BABY RECEIVE THE HEPATITIS B VACCINE?	
DATE OF HEP B VACCINE IF KNOWN:	

DEVELOPMENTAL HISTORY: DOES NOT APPLY TO NEWBORNS

AT WHAT AGE (APPROXIMATELY) DID YOUR CHILD?

	AGE		AGE
ROLL FRONT TO BACK		HAVE FIRST SPECIFIC WORD OTHER THAN MAMA OR DADA	
ROLL BACK TO FRONT		MAKE A TWO WORD SENTENCE	
SIT WITHOUT SUPPORT		PEDAL TRICYCLE	
WALK WITHOUT SUPPORT		DRESS SELF	

<u>CHILD'S MEDICAL HISTORY: DOES NOT APPLY TO NEWBORNS</u>	YES	NO	PLEASE EXPLAIN IF ANSWER IS YES:
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? (If NO - Please Explain)			
HAS YOUR CHILD EVER HAD SURGERY?			
DOES YOUR CHILD HAVE ANY ALLERGIES: TO WHAT?			
DOES YOUR CHILD GET REGULAR DENTAL CARE?			
IS YOUR CHILD ON ANY MEDICATIONS? OTC OR PRESCRIPTION PLEASE LIST:			
HAS YOUR CHILD GONE TO THE E/R THIS PAST YEAR?			
HAS YOUR CHILD EVER HAD:			
EAR INFECTIONS			
MORE THAN 2 STREP THROATS			
PNEUMONIA			
HEART PROBLEMS			
CHICKENPOX			
ANY MAJOR ILLNESS/INJURY			
REACTION TO ANY IMMUNIZATION OR MEDICATION			
URINARY TRACT INFECTION			
WHEEZING OR EVER REQUIRED A BREATHING TREATMENT			
WHOOPIING COUGH			
TB (TUBERCULOSIS)			

FAMILY HISTORY:

CHECK IF CLOSE BLOOD RELATIVES HAVE THE FOLLOWING:

	YES	NO	WHO?		YES	NO	WHO?
ASTHMA				HEART ATTACK < 50 YEARS			
ECZEMA				URINE INFECTIONS			
SICKLE CELL DISEASE				HAY FEVER			
CYSTIC FIBROSIS				HIGH BLOOD PRESSURE			
TUBERCULOSIS				ANEMIA/BLOOD PROBLEMS			
KIDNEY INFECTIONS				LEARNING PROBLEMS			
DIABETES				SEIZURES			
HYPERACTIVITY				EMOTIONAL PROBLEMS			
MENTAL RETARDATION				BORN W/ HEART PROBS			
SUDDEN DEATH				DEATH SHORTLY AFTER BIRTH			
BIRTH DEFECTS							

SCHOOL/DAYCARE BEHAVIOR HISTORY (DOES NOT APPLY TO NEWBORNS):

CHILD'S SCHOOL	GRADE
DOES CHILD ATTEND SPECIAL CLASSES OR SPECIAL HELP?	
ARE YOU CONCERNED ABOUT SCHOOL BEHAVIOR PROBLEMS?	
DOES YOUR CHILD HAVE PROBLEMS WITH :	
	YES NO DOES'NT APPLY
FREQUENT NIGHTMARES	
DIFFICULT TO CONTROL	
FIGHTING A LOT	
TROUBLE MAKING FRIENDS	
BEDWETTING OR STOOLING PROBS	
VISION/HEARING	
APPETITE	
NAME OF CHILD'S PREVIOUS DOCTOR:	
ADDRESS/PHONE NUMBER:	

ARE THERE ANY SPECIFIC ISSUES YOU WOULD LIKE TO DISCUSS WITH YOUR DOCTOR? _____

SIGNATURE OF PERSON COMPLETING FORM: _____ DATE: _____

REVIEWED BY DR. _____

PLEASE PROVIDE US WITH A COPY OF YOUR CHILDS IMMUNIZATION RECORD.

THANK YOU VERY MUCH!!