

## 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	

<b><u>CHILD'S MEDICAL HISTORY: DOES NOT APPLY TO NEWBORNS</u></b>	YES	NO	PLEASE EXPLAIN IF ANSWER IS YES:
ARE YOUR CHILD'S IMMUNIZATIONS UP TO DATE? (If <b>NO</b> - 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	NAME OF CHILD'S PREVIOUS DOCTOR:
FREQUENT NIGHTMARES				
DIFFICULT TO CONTROL				
FIGHTING A LOT				ADDRESS/PHONE NUMBER:
TROUBLE MAKING FRIENDS				
BEDWETTING OR STOOLING PROBS				
VISION/HEARING				
APPETITE				

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 CHILD'S IMMUNIZATION RECORD.

**THANK YOU VERY MUCH!!**