

ASSOCIATED PEDIATRICIANS LLC

NEW PATIENT QUESTIONNAIRE - TO BE FILLED OUT BY PARENT

Child's Name _____ Mother's Name _____ Maiden _____
 Chart # _____ D.O.B. ____/____/____ Occupation _____
 Date ____/____/____ Father's Name _____
 Who is this child's legal guardian(s) _____ Occupation _____

*** If needed go to the back page for more space to answer the question adequately**

A. Pregnancy and Birth:

1. Mother's D.O.B. ____/____/____ Dad's D.O.B. ____/____/____
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 birth weight? _____ lbs. _____ oz.
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 checkups 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, food, insect bites? No / Yes
- *Which ones? _____
5. Has your child had reactions to any immunizations? No / Yes
- *Which ones? _____
6. *Any hospitalizations/surgeries other than for birth? No / Yes
7. Any serious injuries? _____
- *What kind? _____
8. Are any medications taken regularly? No / Yes
- *Which ones? _____

C. Family History:

1. Are the child's parents both in good health? No / Yes
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? 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 him/her? No / Yes
5. For the first 6 months, is he/she (was he/she) breast or bottle fed? _____
6. If still on formula, which one do you use? _____
7. Does he/she take vitamins? No / Yes

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 colds or 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 conditions? No / Yes
11. Has your child 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 18mos. old? No / Yes
4. How does this child compare to others his or her age? _____
5. Does he/she have any trouble sleeping? No / Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No / Yes
8. Does he/she get along with other children? No / Yes
9. 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? No / Yes
3. Is there a working smoke alarm on each floor in 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, or mice) No / Yes
7. Does your child always wear a helmet when biking and skating? No / Yes

- H. Do You Have A Record Of Immunizations?** No / Yes
- Chicken pox status? _____

How did you find out about our practice? _____

