

NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PATIENT

Child's Name _____ D.O.B. _____

NAME
CHART
DATE

Mother's Name _____ Age _____

Occupation _____

Father's Name _____ Age _____

Occupation _____

If adults in the household work outside the home, what child care arrangements are made for this child?

A. PREGNANCY AND BIRTH

1. Mother's age at time of child's birth? _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins or iron? No Yes
4. Was the baby born on time? No Yes
5. What was the birthweight? _____
6. Did the baby have trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?) What kind? _____

Comments: _____

B. PAST MEDICAL HISTORY

1. Where has your child gone for checkups until now? _____
2. Date of last checkup? _____
3. Date of last dental checkup? _____
4. Has your child had allergic reactions to any medications, foods, insect bites? Which ones? No Yes

5. Has your child had reactions to any immunizations? Which ones? No Yes

6. Any hospitalizations other than that for birth? For what? No Yes

7. Any serious injuries? What kind? No Yes

8. Are any medications taken regularly? Which ones? No Yes

9. Chicken Pox? No Yes

C. FAMILY HISTORY

1. Are the child's parents both in good health? No Yes
2. Circle any disease that this child's parents, grandparents, brothers, sisters, aunts or 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/sisters:

Age	Sex	Health
1		
2		
3		
4		

Comments: _____

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? No Yes
2. Is it now? No Yes
3. Was there severe colic or any unusual feeding problems 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 fed or bottle fed? _____
6. If still on formula, which one do you use? _____
7. Does he/she take vitamins?

Comments: _____

(Continued on back)

