PARTNERS IN PEDIATRICS, LLC
NEW PATIENT QUESTIONNAIRE
TO BE FILLED OUT BY PARENT

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?_____

_____

PATIENT NAME_____

CHART #_____

DATE_____

A. PREGNANCY AND BIRTH:

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

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups 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, foods, insect bites? Yes No
   If yes, which ones?_____
5. Has your child had reactions to any immunizations? Yes No
   If yes, which ones?_____
6. Any hospitalizations other than for birth? Yes No
   If yes, what for? _____
7. Any serious injuries? Yes No
   If yes, what kind?_____
8. Are any medications taken regularly? Yes No
   If yes, which ones?_____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? Yes No
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? Yes No

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? Yes No
4. Do any foods disagree with him/her? Yes No
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? Yes No

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? Yes No
2. Any eye problems? Yes No
3. Has he/she had any problems with teeth? Yes No
4. Does he/she have frequent colds or sore throats? Yes No
5. Is there asthma, pneumonia, or recurrent cough? Yes No
6. Does he/she have a heart murmur or any heart problems? Yes No
7. Any problems with urination? Yes No
8. Any problems with diarrhea or constipation? Yes No
9. Have there been any convulsions or other problems with the nervous system? Yes No
10. Any eczema, hives, or other skin conditions? Yes No
11. Has your child ever been anemic? Yes No
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 1½ years old? Yes No
4. How does this child compare to others his or her age? Yes No
5. Does he/she have any trouble sleeping? Yes No
6. What grade is he/she in? Yes No
7. Has he/she had any trouble in school? Yes No
8. Does he/she get along with other children? Yes No
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? _____
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor in the house? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Are there any smokers in the household? Yes No
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice) Yes No
7. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No