QUESTIONNAIRE: NEW PEDIATRIC PATIENT (page 1 of 2)

Patient Name: _____ DOB: _____

Mom's Name (or legal guardian): _____ (maiden name) _____

Dad's Name (or legal guardian): _____

Parent's Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Remarried

Stepparent's Name (if applicable): _____

Who does your child live with: _____ Does your child feel safe at home? ☐ Yes ☐ No

Does your child: ☐ go to day care ☐ school ☐ stay home with mother, father, or caregiver

Immunizations: ☐ Up to date ☐ Behind schedule ☐ Limited ☐ No vaccinations

** PLEASE BRING VACCINE CARD WITH YOU TO ***ALL*** WELL-CHILD AND SCHOOL/SPORTS PHYSICAL VISITS**

Birth Information

Born at how many weeks?	By Vaginal or Cesarean delivery?	Birth Weight?	Birth Length?

Any complications of pregnancy or delivery? _____

Did your child: ☐ Go home with mother or ☐ Require a stay in the NICU?

Is/was your child ☐ Breast fed? ☐ Bottle fed? Type of formula? _____ ☐ Both?

Does your child smoke? ☐ Yes ☐ No Does anyone that lives with your child smoke? ☐ Yes ☐ No

Please list all medications (including over the counter medications and vitamins) that your child is currently taking:

Medication	Strength	Frequency	Last Dose

Please list all of your child's allergies, including foods, along with the type of reaction:

Medication/ Food	Type of Reaction

Please list all of your child's previous surgeries:

Date of Surgery	Type	Anesthesia / Complications, if any

Please list all of your child's previous hospitalizations:

Date	Hospitalization

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QUESTIONNAIRE: NEW PEDIATRIC PATIENT (page 2 of 2)

Please list all of your child's chronic illnesses or major health problems.:

Family Member	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Healthy	Unknown	Deceased
Father	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Mother	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Son(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Daughter(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Brother(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									
Sister(s)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other:									

How many? Brothers: _____ Sisters: _____ Sons: _____ Daughters: _____

Other pertinent medical history:

What are your concerns today about your child's health?

1. _____
2. _____
3. _____

Please check **any** of the following symptoms that your child is having today:

1. ☐ fever ☐ growth issues ☐ chills ☐ fatigue ☐ fussiness or irritability ☐ swelling anywhere
2. ☐ sleeping problems ☐ behavior ☐ trouble at school ☐ depression ☐ anxiety
3. ☐ trouble eating ☐ difficulty swallowing ☐ stomach pain ☐ nausea ☐ vomiting ☐ diarrhea
4. ☐ trouble urinating ☐ bed wetting ☐ smelly urine ☐ pain when urinating ☐ frequent urination
5. ☐ discoordination ☐ seizures ☐ tremors ☐ headaches
6. ☐ runny nose ☐ post nasal drip ☐ seasonal allergies ☐ history of ear infections or tonsillitis
7. ☐ eye pain ☐ trouble seeing ☐ cross eyes or "lazy" eye ☐ eye discharge
8. ☐ trouble breathing ☐ cough ☐ wheezing with or without exercise ☐ history of pneumonia
9. ☐ heart trouble ☐ high blood pressure ☐ heart murmur
10. ☐ pain in joints, muscles, or back ☐ weakness
11. ☐ rashes ☐ moles ☐ lumps ☐ bumps ☐ acne
12. ☐ pain in genital area ☐ discharge in genital area

For whom do you give us permission to talk to regarding your healthcare services? _____

I have carefully reviewed this questionnaire and completed it to the best of my knowledge:

_____ _____

Signature of Patient, Parent, or Legal Guardian (circle one) Date / Time

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