New Patient 3 month+ History Questionnaire

CHILD'S NAME: _____ | DOB _____
FORM COMPLETED BY: _____

Household

What is the child's living situation?
Lives with:
___ Biological Parents
___ Adoptive Parents
___Foster Family
___Joint Custody
___Single Custody
(if so, who do they live with:
_____
Other: _____

Please list all those living in the child's home:

Name:	Relationship to Child:	Age:

Birth History ___ I do not know the birth history

Birth weight _____
Was the child born at term? Yes No
If preterm, how many weeks _____
Was the baby conceived by IVF or other forms of assisted fertility? Yes No
If yes, did you use a donor egg or donor sperm? _____
Were there any prenatal or neonatal complications? Yes No
Explain: _____

During pregnancy, did mother:
Use tobacco Yes No
Drink alcohol Yes No
Use drugs Yes No
Take medication Yes No
Explain: _____

Any other information you feel the pediatrician should know?
_____
_____

General Medical History ___ I do not know (DK)

Do you consider your child to be in good health? Yes No DK
Explain:
_____
_____

Has your child had any surgery? Yes No DK
If applies:

Surgery List:	Dates:	Hospital:	Surgeon:

Turn over →

Has your child every been hospitalized? Yes No DK

Dates:	Hospital:	Reason:

Is your child **allergic** to any medication or food? Yes No DK
Explain:

_____

Current Medications:

_____

_____

Any significate past medications the doctor should know about? _____

Past History

___ I do not know (DK) the child's past history

Does your child have, or has your child ever had	**Y**	**N**	**DK**	**Explain**
Chickenpox				When:
Frequent ear infections/ problems with ears or hearing				
Asthma, bronchitis, bronchiolitis, or pneumonia				
Any heart problems / heart murmur / high blood pressure				
Anemia / bleeding problems / blood transfusions				
Frequent abdominal pain/ intestinal problems/constipation				
Recurrent urinary tract infections				
Kidney disease or urological malformations				
Bed-Wetting (after 6 years old)				
Eye Problems/ Cataracts/ Retinoblastoma				
Metabolic/ Genetic Disorder				
Sleeping problems / snoring				
Chronic or recurrent skin problems (eg, acne, eczema)				
Immune Problem/TB/ HIV				
Autoimmune Disease				
Cancer or Tumor				
Frequent Headaches/ Migraines				
Seizure Disorder				
Obesity/ Eating Disorder				
Diabetes				
Thyroid or other endocrine problems				
History of serious injuries/ fractures/concussions				
ADHD				
Learning Disabilities / Cognitive Delay				
Developmental Delay				
Autism				
Anxiety/ Mood problems/ Depression/ Psychiatric Illness				
History of family violence				

Any other signification problem:

_____

Turn over →