PEDIATRIC NEW PATIENT QUESTIONNAIRE
4 OR YOUNGER

Name: _____
Today's Date: _____
Date of Birth: _____

Dear Patients: Please complete as much of this form as you can.
It will help us learn more about your child and help us to give him/her a better examination.

Current Information

What is the reason for today's visit? _____

_____

Is your child now taking any medications? _____

List any medications to which your child may be allergic and describe the reaction: _____

_____

_____

Does your child have any severe reaction to foods or insect bites? _____

_____

Past History

Pregnancy and Birth (this child)

Age of mother at time of birth: _____

Total number of pregnancies: _____ Living children: _____ Miscarriages or stillbirths: _____

This was pregnancy number: _____

The pregnancy was: ❒ 9 months ❒ premature ❒ prolonged

Was the pregnancy complicated by: ❒ anemia ❒ bleeding ❒ high blood pressure ❒ illness or infection ❒ diabetes ❒ need for any medication

❒ Other _____

_____

Where was this child born? _____

Birth weight: _____ Length: _____

Was the delivery: ❒ breech delivery ❒ Caesarean section ❒ forceps delivery ❒ under general anesthesia (gas) ❒ difficult or prolonged

❒ Other _____

Feeding History

Breast fed _____ months. Formula fed _____ months. Name of formula: _____

Solid food began at _____ months. Table food at _____ months. Does your child eat well? _____

Are there foods your child cannot eat (list)? _____

Do you give vitamins? _____ Name(s): _____

Growth and Development

Cities in which child has lived: _____

Do parents or caretakers smoke? ❒ Yes ❒ No

Are there pets in the home/yard? _____

Does patient eat dirt, paint or other nonfood items? _____

Please list any hospitalizations, operations, injuries, or serious illnesses and the year or age they occurred:

_____

_____

_____

Immunizations

Is your child up to date? _____ (Please provide us with a copy of the immunizations.)

Hospitalizations and medical problems

Please list any hospitalizations, operations, injuries or serious illnesses, and the year they occurred: _____

_____

_____

_____

Family History

	Name	Age/Height/Weight	Condition of Health	Occupation
Mother				
Father				
Siblings				

Please list relationships of immediate or extended family members who have the following problems:

Allergies: _____

Asthma: _____

Blood disorders, including Sickle Cell: _____

Birth defects: _____

Bleeding problems: _____

Convulsions or epilepsy: _____

Cystic Fibrosis: _____

Diabetes (adult or childhood): _____

Heart disease in children: _____

Heart disease in adults under 55 years:

Heart attacks: _____ Hardening of the arteries: _____

Strokes: _____ Heart bypass: _____

Angina: _____

High cholesterol (over 240 or on medication): _____

High blood pressure: _____

Mental retardation: _____

Migraine headaches: _____

Thyroid disease: _____

Tuberculosis: _____

Other: _____

Does your child have a history of the following problems?
(Now or in the past)

- ❒ Allergy, hay fever, or sinus problems
- ❒ Asthma, wheezing, or shortness of breath
- ❒ Bronchitis or pneumonia
- ❒ Chronic cough
- ❒ Frequent ear infections
  (How many?_____Needed PE tubes?_____)
- ❒ Frequent throat infections, tonsillitis, or colds
- ❒ Hearing problems
- ❒ Heart murmur or other heart problems
- ❒ Convulsion, febrile seizure, or staring spells
- ❒ Head injury or concussion
- ❒ Unusual clumsiness
- ❒ Eating problems
- ❒ Excessive sweating
- ❒ Excessive thirst
- ❒ Growth problems or weight loss
- ❒ Abdominal pain, chronic
- ❒ Bloody or tarry stools
- ❒ Constipation or diarrhea
- ❒ Vomiting or nausea, chronic
- ❒ Anemia
- ❒ Easy bleeding or bruising
- ❒ Sickle cell trait or disease
- ❒ Chickenpox
- ❒ Measles
- ❒ Exposure to tuberculosis
- ❒ Frequent unexplained fever
- ❒ Deformity or swelling of limbs
- ❒ Urinary tract or bladder infections
- ❒ Frequent or painful urination
- ❒ Eczema or other skin problems