



NEW PATIENT QUESTIONNAIRE
TO BE FILLED OUT BY PARENT

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Mother's name: Age: Patient:
Occupation: Account:
Father's name: Age: Date:

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

PREGNANCY AND BIRTH

Mother's age at birth:
Did mother have any illness during pregnancy? No Yes
Did mother take any medications other than vitamins and iron? No Yes
Was the baby born on time? No Yes
What was the birth weight?
Did the baby have any trouble starting to breathe? No Yes
Did the baby have any trouble while in the hospital? Jaundice, infections, other? What Kind?

PAST MEDICAL HISTORY

Where has your child gone for check-ups until now?
Date of last check-up:
Date of last dental check-up:
Has your child had reactions to any medications, foods, insect bites? No Yes
Which ones?
Has your child had reactions to any immunizations? No Yes
Which ones?
Any hospitalizations other than at birth? No Yes
Age/reason:
Any serious injuries?
What kind?
Are any medications taken regularly? No Yes
Which ones?

FAMILY HISTORY

Are the child's parents both in good health? No Yes
Circle any diseases that this child's parents, grandparents, brothers, sisters, or other relatives have had:
anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness,
drug problems, alcohol problems, inherited illness, cancer, AIDS, others
List age, sex, and general health of brothers and sisters:

Have any of your children died? No Yes

REVIEW OF SYSTEMS

Has your child had any of the following:
Frequent ear infections? No Yes
Eye problems? No Yes
Problems with teeth? No Yes
Frequent colds or sore throats? No Yes
Asthma, pneumonia, or recurrent cough? No Yes
Heart murmur or any heart problems? No Yes
Problems with urination? No Yes
Problems with diarrhea or constipation? No Yes
Convulsions or other problems with the nervous system? No Yes
Eczema, hives, or other skin conditions? No Yes
Anemia? No Yes

Please list any other medical problems: