NEW PATIENT QUESTIONNAIRE – PEDIATRICS

Patient Name: ____ Date of Birth: ______________________
Reason for 1st appointment needed:____
Questions or concerns you would like addressed at 1st appointment:__________________________________
____
Previous Physician:____________________________________ City/State:__________________________
How did you hear about our office?____

PAST MEDICAL HISTORY

Does your child *currently have* or *have been treated for* any of the following? (check all that apply)

	Diagnosis	Last Seen/Treated for		Diagnosis	Last Seen/Treated for
	ADHD/Behavioral Health			Sickle Cell Anemia	
	Allergies			Tuberculosis (TB)	
	Asthma			Seizures/Epilepsy	
	Reflux			Heart Disease	
	Noisy breathing			Lung Disease	
	Sleep Apnea			Kidney Disease	
	Hearing Loss			Meningitis	
	Ear Diseases			Bleeding Disorders	
	Cancer (Type:________________)			Transplant (Type:_______________)	
	Other:				

HOSPITALIZATIONS (*please list*)

Date | Reason | Hospital
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________

SURGERIES (*please list*)

Date | Reason | Hospital
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________
______________________ ________________________________ __________________________

CURRENT MEDICATIONS (*including vitamins, herbs, and over-the-counter*)

Name: | Dose: | Doing well on this Rx? | Issues/Concerns:
______________________ ____________________ _____Yes ______No __________________
______________________ ____________________ _____Yes ______No __________________
______________________ ____________________ _____Yes ______No __________________
______________________ ____________________ _____Yes ______No __________________

Do you have any **ALLERGIES TO MEDICATIONS**? ____Yes ____No
If yes, please list the medicine and describe the reaction:____
____

NEW PATIENT QUESTIONNAIRE (continued) – PEDIATRICS

FAMILY HISTORY (*Please check all that apply to your family members*)

___Allergy	___Asthma	___Cystic Fibrosis
___Ear Infections	___Hearing Loss/Deafness	___Bleeding Disorders
___Thyroid Disease	___Problems with Anesthesia	___Cancer (type:____________________)

SOCIAL HISTORY

*Are your child's immunizations up to date? ___Yes ___No
*Is your child currently in daycare? ___Yes ___No
*Is your child exposed to tobacco smoke? ___Yes ___No
*Is there concern for suspected abuse, physical assault, sexual molestation/rape, domestic violence, unsafe living conditions, substance abuse or caregiver with psychiatric diagnosis in the home? ___Yes ___No
*Does your child live in or regularly visit a home built before 1978 (lead risk purposes)? ___Yes ___No
*In the past year, has your child been exposed to repairs, repainting, or renovations of a home built before 1978? ___Yes ___No

BIRTH HISTORY

*Was your child born prematurely? ___Yes ___No
If yes, by how many weeks? __________________
*What was your child's birth weight? ___lbs ___ounces
*Has your child ever needed a breathing tube or ventilator? ___Yes ___No
*Did your child pass their newborn hearing screening test? ___Yes ___No
*Did your child have any problems at the time of delivery? ___Yes ___No

OTHER IMPORTANT MEDICAL INFORMATION NOT LISTED ON THIS QUESTIONNAIRE:

____

____

____

____

Questionnaire completed by:

____

Signature Relationship to Patient Date

FOR OFFICE USE ONLY

____

Physician Acknowledgement Date