QUESTIONNAIRE: NEW PEDIATRIC PATIENT (Birth – 12 Years)

Patient Name: _____ Date of Birth: _____

Preferred Name/Nickname: _____ Today's Date: _____

Birth History

Place of Birth: _____

Birth Weight: _____

Problems at Birth: ☐ Yes ☐ No

_____

_____

_____

Number of days in the hospital: # _____

Premature? ☐ Yes ☐ No If so, how much? _____

Medical History

Hospitalizations: ☐ Yes ☐ No

- Why? _____
  When? _____
  Where? _____
- Why? _____
  When? _____
  Where? _____

Surgeries: ☐ Yes ☐ No

- Type of surgery? _____
  When? _____
  Where? _____
- Type of surgery? _____
  When? _____
  Where? _____

Allergic to Medications: ☐ Yes ☐ No

Medication	Reaction
_____	_____
_____	_____
_____	_____

Environmental/Food Allergies: ☐ Yes ☐ No

Allergy	Reaction
_____	_____
_____	_____
_____	_____

Medical History:

Condition	Year diagnosed/Specialist Name
☐ Asthma	_____
☐ Wheezing	_____
☐ Pneumonia	_____
☐ Ear Infections	_____
☐ ENT Disorders	_____
☐ Hearing Problems	_____
☐ Visions Problems	_____
☐ Gastrointestinal Disorder	_____
☐ Bladder/Urine Infections	_____
☐ Fractures	_____
☐ Behavior Problems	_____
☐ Developmental Concerns	_____
☐ Other	_____

Medications Prescribed and over-the-counter. Include vitamins, herbs, and home remedies.

Medication	Dose	Times Per Day

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Patient Label

Mother's Pregnancy History

Prenatal Care ☐ No ☐ Yes Where/Name of Provider: _____

Any medical problems during your pregnancy? ☐ No ☐ Yes If so, please list: _____

_____

List medications taken during pregnancy, both for the pregnancy and routine as prescribed by your doctor. Include vitamins, herbs, and home remedies.

Medication	Dose	Times Per Day	Medication	Dose	Times Per Day

Tobacco Use During Pregnancy: ☐ Never

☐ Cigarettes ☐ Packs/day _____ ☐ Other _____

Alcohol Intake During Pregnancy: ☐ Yes ☐ No ☐ Drinks/week _____

Is alcohol a concern for you/others? ☐ Yes ☐ No

Drug Use During Pregnancy: (Including cannabis/marijuana) ☐ Yes ☐ No What kind? _____

Family History of Child:

Check all that applies to each family member.	AGE	Mental Health Disorder	ADHA/ Learning Disorders	Alcohol/Drug abuse	Cancer	Leukemia	Diabetes	High Blood Pressure	High Cholesterol	Respiratory disorder	Heart disease	Birth defects	Seizure disorder	Cause of Death
Mother														
Father														
Sisters														
Brothers														
Maternal Grandfather														
Maternal Grandmother														
Paternal Grandfather														
Paternal Grandmother														
Other:														

Does your child spend time with a parent that is not living in the household? ☐ Yes ☐ No

Please explain: _____

Please list all people living in your child's household: _____

_____

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

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

Parent/Legal Representative Signature: _____ Date: _____ Time: _____

Relationship to Patient: _____