New Patient Questionnaire

Patient's Name_______________________________________ Date of Birth ___________________

Who lives at home with the patient? ____

Smokers? No Yes (Inside Outside) Pets? _____________________________

Childcare? In Home Family Babysitter Daycare

School: Name & Grade ____

School Performance ____

Activity Level? Sedentary Active Competitive Sports

Amt of TV/Video Games daily? ________ min/day

Uses seatbelts car seat booster seat

Birth History

Any problems during the pregnancy? No / Yes ______________________________________

Was mom on any medications? No / Yes ____

Cigarettes Alcohol Drugs used During the Pregnancy? No

If Yes ____

Birth Hospital? _________________________________ Birth Weight _______lbs ________ oz

Was your baby born: On Time Early (weeks ________) Late (weeks __________)

How was your baby born? Vaginally Delivery C-Section Vacuum Forceps

Any problems with the baby at birth? No Yes ______________________________________

Did they go home with mom from the hospital? Yes No ______________________________

Past Medical History

When was your child's last well-check? ____

Previous Doctor? ____________________________ Dentist? ______________________

Does your child take any medications? No Yes __________________________________

Any Medication Allergies? No Yes ____

Prior Hospitalizations? No Yes ____

Is your son circumcised? No Yes

Other Prior Surgeries No Yes ____

Please Check all that apply and explain. Has your child had a history of:

ADHD/ADD ____

Anemia ____

Asthma Wheezing ____

Bedwetting ____

Cerebral palsy ____

Constipation ____

Developmental Delay ____

Diabetes requiring insulin/Type I DM ____________________________________

Ear infections ____

Eczema ____

Food Allergies ____

Headache ____

Hearing Loss ____

Heart Murmur ____

Broken Bones ____

Chicken Pox ____

Insulin Resistance / Type II DM ____

Obesity ____

Pneumonia ____

Seasonal Allergies ____

Seizures ____

Sports Injury ____

Urinary Tract Infection ____

Urticaria / Hives ____

Vaccine Reaction ____

Vision Problems ____

Vitamin D Deficiency ____

Other : ____

Family History

Considering the child's parents, grandparents, aunts, uncles, and siblings, is there a family history of:

Family History is unknown

ADHD/ADD Whom: ____

Alcohol or Drug Abuse Whom: __________________________________

Allergies Whom: ____

Anemia Whom: ____

Bleeding Disorder Whom: ____

Cancer Whom: ____

Skin Cancer Whom: ____

Breast Cancer Whom: ____

Childhood or Sudden Infant Death Whom: ____________________

Developmental Delay Whom: __________________________________

Diabetes Whom: ____

Seizures Whom: ____

Hearing Problems / Deafness Whom: ______________________________[1]_

Heart Disease Whom: ____

High Blood Pressure Whom: ___________________________________

High Cholesterol Whom: ____

Intellectual Disability Whom: ____

Kidney Disease Whom: ____

Liver Disease Whom: ____

Mental Illness / Depression Whom: _________________________________

Retinoblastoma Whom: ____

Stroke / blood Clots Whom: _______________________________________

Vision Problems Whom: ____

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[1] GLD 2/2015