Summerwood Pediatrics

NEW PATIENT QUESTIONAIRE - TO BE FILLED OUT BY PARENT

Child's Name _____ D.O.B. _____
Child's S.S.# _____ Chart # _____ Date _____
Mother's Name _____ D.O.B. _____ S.S.# _____
Occupation _____
Father's Name _____ D.O.B. _____ S.S.# _____
Occupation _____

A. Pregnancy and Birth:

1. Mother's age at birth? _____ Other Children: _____
2. Did Mother have any illness during pregnancy? No Yes
   If yes, explain: _____
3. Did she take any medications other than vitamins and iron? No Yes
   If yes, explain: _____
4. Was the baby on time? Yes No
   If not, specify: _____
5. What was the birthweight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? No Yes
   (jaundice, infections, other?)
   If yes, explain: _____

B. Past Medical History:

1. Previous Physician: _____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, foods, or insect bites? No Yes
5. Has your child had reactions to any immunizations? No Yes
6. Any hospitalizations other than for birth? No Yes
7. Any serious injuries? No Yes
8. Are any medications taken regularly? No Yes
9. Other Illnesses? No Yes
10. Has your child ever been on any medication for attention deficit or psychiatric problem? No Yes

If you answered yes to any of the above questions 4-10, please explain:

_____
_____

C. Family History:

1. Are the child's parents both in good health? Yes No
   If no, explain _____
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts or uncles have had:
   Anemia, Asthma, Allergies, Diabetes, High Blood Pressure
   Heart Trouble, Tuberculosis, Drug/Alcohol Dependencies, Attention Deficit
   Inherited Illness, Venereal Disease, Cancer, AIDS, Mental Illness, Seizures
   Comments: _____
   _____
3. List date of birth, sex, and general health of the child's brothers and sisters:
   1. _____ 3. _____ 5. _____
   2. _____ 4. _____ 6. _____
4. Do you have any children that are deceased? No Yes
   If yes, explain: _____

D. Feeding and Nutrition:

1. Is your child's appetite usually good? Yes No
2. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
3. Do any foods disagree with him/her? No Yes
4. Was he/she breast fed or bottle fed? _____
5. If still on formula, which one do you use? _____
6. Has your child had to change formula? Yes No
7. Does he/she take vitamins? Yes No
   If yes, what vitamins? _____

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E. Review of Systems:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there a history of asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any chronic problems with diarrhea or constipation? No Yes
9. Any history of recurrent vomiting or reflux? No Yes
10. Have there been any convulsions or other problems with the nervous system? No Yes
11. Any eczema, hives, or other skin conditions? No Yes
12. Has your child ever been anemic? No Yes
13. Is there a history of poor weight gain/obesity/eating disorder? No Yes

If you answered yes to any of the above, please explain:

_____
_____
_____
_____

F. Development / Behavior:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1½ yrs. old? Yes No
4. Does he/she have any trouble sleeping? No Yes
5. What grade is he/she in? _____ Performance: _____
6. Has he/she had any trouble in school? No Yes
7. Does he/she generally get along with other children? Yes No
8. Circle if your child has had any of the following:
   Nail Biting, Thumb Sucking, Bed Wetting, Toilet Training Problems
   Bad Temper, Hyperactivity, Nightmares, Speech Problems
   Problems with Discipline, learning disability or other behavior problems?
   If you answered yes to any of the above, please explain:

_____
_____
_____
_____

G. Safety / Environment

1. Do you live in a private house, apartment, mobile home? (circle)
2. Is there a working smoke alarm and carbon monoxide detector on each floor in the house? Yes No
3. Does your child always use a car seat/seat belt when riding in a car? Yes No
4. Are there any smokers in the household? No Yes
   Specify: _____
5. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice)? No Yes
6. Does your child always wear a helmet when riding a bicycle? Yes No

H. What are your main concerns or problems with your child?

_____
_____
_____
_____
_____