Lakeshore Pediatric Center

NAME: _____
DATE: _____

NEW PATIENT QUESTIONNAIRE
Mother's Name _____
Occupation _____
Father's Name _____
Occupation _____
If adults in the household work outside the home, what child care arrangement are made for this child?

_____

PREGNANCY AND BIRTH

I. Mother's age at child's birth _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron? No Yes
4. Was the baby on time _____ Early? _____ Late?_____
5. Vaginal Delivery or C-section? (Circle one)
5 What was the baby's birth weight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) No Yes
What kind? _____

_____

PAST MEDICAL HISTORY

1. Where has your child gone for well checkups until now? _____
Date of last checkup:
2. Date of last dental checkup:
3. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
4. Has your child had reactions to any immunizations? No Yes
5. Any hospitalizations other than birth? No Yes
For what? _____
6. Any serious injuries? No Yes
What kind? _____
7. Are any medications taken regularly? No Yes
Which ones? _____
8. Any prior surgeries? No Yes
What kind? _____

_____

FAMILY HISTORY

1. Are the child's parents both in good health? No Yes
2. List age, sex, and general health of patient's brothers and sisters: _____

_____

3. Have any of your children died? No Yes

FEEDING AND NUTRITION

1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Were there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? _____
6. If still on formula, which one do you use?_____
7. Does he/she take vitamins? No Yes

REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Has he/she had any problems with teeth? No Yes
3. Does he/she have frequent colds or sore throats? No Yes
4. Is there asthma, pneumonia, or recurrent cough? No Yes
5. Does he/she have a heart murmur or any heart problems? No Yes
6. Any problems with urination? No Yes
7. Any problems with diarrhea or constipation? No Yes
8. Have there been any convulsions or other problems with the nervous system? No Yes
9. Any eczema, hives, or other skin conditions? No Yes
10. Has your child ever been anemic? No Yes
11. Circle if your child has had any of the following:
Nail biting, thumb sucking, bedwetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others:

_____

12. Please list any other problems: _____

_____

DEVELOPMENTAL HISTORY

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 18 months old? No Yes
4. How does this child compare to others his/her age?

_____

5. Does he/she have trouble sleeping? No Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No Yes
8. Has he/she had to repeat a grade? No Yes
9. Does he/she get along with other children? No Yes

SAFETY/ENVIRONMENT

1. (Circle) Do you live in a private house, apartment, mobile home, other?_____
2. Do you know the hottest temperature of the water in the pipes? No Yes
3. Is there a working smoke alarm on each floor in the house? No Yes
4. Does your child always use a car seat/seat belt when riding in a car? No Yes
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (Peeling paint, insects, rats, or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes
8. Are there any guns in the home? No Yes
Do you have a record of immunizations? No Yes

PLEASE COMPLETE ADDITIONAL HISTORY ON BACK OF THIS PAGE.

FAMILY HISTORY

Have any family members had the following:

Deafness	Yes	No	Who_____	Comments _____
Nasal allergies	Yes	No	Who_____	Comments _____
Asthma	Yes	No	Who_____	Comments _____
Tuberculosis	Yes	No	Who_____	Comments _____
Heart disease (before age 50)	Yes	No	Who_____	Comments _____
High blood pressure (before age 50)	Yes	No	Who_____	Comments _____
High cholesterol	Yes	No	Who_____	Comments _____
Anemia	Yes	No	Who_____	Comments _____
Bleeding disorder	Yes	No	Who_____	Comments _____
Liver disease	Yes	No	Who_____	Comments _____
Kidney disease	Yes	No	Who_____	Comments _____
Diabetes (before age 50)	Yes	No	Who_____	Comments _____
Bed-wetting (after age 10)	Yes	No	Who_____	Comments _____
Epilepsy or convulsions	Yes	No	Who_____	Comments _____
Alcohol abuse	Yes	No	Who_____	Comments _____
Drug abuse	Yes	No	Who_____	Comments _____
Mental illness (depression, anxiety, etc)	Yes	No	Who_____	Comments _____
Mental retardation	Yes	No	Who_____	Comments _____
Immune problems, HIV, AIDS	Yes	No	Who_____	Comments _____
Thyroid problems	Yes	No	Who_____	Comments _____
Inherited illness	Yes	No	Who_____	Comments _____
Cancer	Yes	No	Who_____	Comments _____

Additional family history

_____

_____

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_____

_____

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