New/Annual Patient Questionnaire

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Name:_____ Date of Birth/Age:_____

Sex: [ ] Male [ ] Female Name of person accompanying child:_____

Mother's Name and Occupation:_____

Father's Name and Occupation:_____

Reason for visit:_____

Has your child been seen by any other provider for this concern? [ ] Yes [ ] No

If yes, name and location of provider:_____

Medical History:

Previous Pediatrician's Name and Location (new patients only) :_____

_____

Your child's immunization status: [ ] Up to Date [ ] Not Up to Date [ ] Unimmunized [ ] Unsure

Is your child allergic to anything?_____

List all of your child's medications, including frequency and dosage (including over-the-counter medications, vitamins/supplements, and alternative therapies):

1)_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

Please list any **medical problems, past or present**, that your child has been treated for by a medical provider (examples: asthma, allergies, ADHD, congenital malformations, diabetes):

_____

_____

_____

_____

Please list any surgeries and approximate dates:

_____

_____

Please list the approximate dates and reasons for any hospitalizations:

_____

_____

Family History

Please check any illnesses, if known, pertaining to the relatives listed below:

**If your child was adopted or family's medical history is unknown, please check here : [ ]

	Deceased	Diabetes	High Blood Pressure	Heart Disease	Autoimmune Diseases	Psychiatric Problems	Congenital Disease	Asthma	Other (please list)	History Unknown
Mom										
Dad										
Brother #1										
Brother #2										
Sister #1										
Sister #2										
Maternal Grandmother										
Maternal Grandfather										
Paternal Grandmother										
Paternal Grandfather										
Other: _____										

Social History

Who lives at home with the child?

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Parents Marital Status: [ ] Married [ ] Divorced [ ] Separated [ ] Remarried [ ] Never Married

Does anyone that lives in the child's home smoke? [ ] Yes [ ] No If yes, who?_____

Are there pets in the home? [ ] Yes [ ] No If yes, what kinds and how many?_____

What school does your child attend? _____ [ ] Home schooled

What grade is your child in? _____ School Performance: [ ] Above average [ ] Average [ ] Below average

Have the teachers noted any discipline problems? [ ] Yes [ ] No If yes, please explain:_____

_____

Does your child receive any additional supports at school: [ ] Yes [ ] No If yes, please explain:_____

_____

Please list on average the number of hours per day your child spends doing the following activities:

Playing Sports_____ Doing homework _____ Playing outside _____

Watching TV_____ Talking/texting/playing on cell phone_____ Playing video games/Ipad_____

Computer/Internet_____ Sleeping _____

Does your child have a computer/TV in his or her bed room? [ ] Yes [ ] No

Please list any sports your child actively participates in:_____

Please list anything else that you would us to know about your child: _____

_____