

Family Medicine at Sterling Ridge

PEDIATRIC - NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: ____/____/____ Sex: F M

Your name: _____ Relationship to child: _____

Where do you live: _____ Referring Physician: _____

Mother's name: _____ Age: _____ Occupation: _____

Father's name: _____ Age: _____ Occupation: _____

Who lives in the home with this child? Number of adults: _____ Number of Children: _____

Please list the names and ages of brothers and sisters:

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Name: _____ Age: _____ Health Status: _____

Pets: _____ Type: _____ Type of home: Apartment Trailer House

Smokers in Household? Yes No Who? _____

Water Source: City Well Bottled County

MEDICAL HISTORY

Pregnancy History: Did patient's mother use any of the following substances or have any of the following symptoms during pregnancy?

Y N Don't Know

DOCTOR'S NOTES

	Y	N	Don't Know	
Medications: Please name:				
Street drugs: Please name:				
Alcohol				
Smoking				
Vaginal infection				
Urine infection				
Other Problems:				

Birth History:

How long was the pregnancy:	
What hospital was the baby born at?	
What was the baby's birthweight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	
Did the baby have any problems? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know	

MEDICAL HISTORY, continued....

	Y	N	Don't Know	DOCTOR'S NOTES
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have any allergies? To what?				
Does your child get regular dental care?				
Is your child on any medications? Please list:				
Has your child gone to an ER this past year?				
Has your child ever had:				
Ear infections?				
More than 2 strep throats?				
Pneumonia				
Heart problems				
Chickenpox				
Any major illness				
Reaction to any immunization or medications?				
Urinary tract infections?				
Wheezing?				

Family History: Check if close blood relatives have the following:

Disease	Y	N	Who?	Disease	Y	N	Who?
Asthma				Heart attack < 50 yrs			
Sickle cell disease				Urine infections			
Cystic fibrosis				Hayfever			
Tuberculosis				High blood pressure			
Kidney infections				Anemia blood problems			
Diabetes				Learning problems			
Hyperactivity				Seizures			
Mental retardation				Emotional problems			
Sudden death				Born w/heart problems			
Birth defects				Death shortly after birth			

School / Daycare Behavior History

Child's school _____ Grade: _____

	Y	N	Don't know	Doctor's Notes
Does child attend special classes or receive special help?				
Are you concerned about school behavior problems?				
Does your child have problems with:				
Frequent nightmares			N/A	
Difficult to control?			N/A	
Fighting a lot			N/A	
Trouble making friends?			N/A	
Bedwetting or stooling problems?			N/A	
Vision / Hearing			N/A	
Appetite			N/A	

Name of child's previous doctor: _____ Address: _____

Are there any specific issues you would like to discuss with your doctor? _____

Signature of person completing form: _____ Date: _____ Relationship to patient _____

Reviewed by Dr. _____ Date: _____