PEDIATRIC NEW PATIENT QUESTIONNAIRE
4 OR YOUNGER

Name: _____ Date of Birth: _____

Today's Date: _____

Dear Patients: Please complete as much of this form as you can. It will help us learn more about your child and help us to give him/her a better examination.

Current Information

What is the reason for today's visit? _____

_____

Is your child now taking any medications? _____

List any medications to which your child may be allergic and describe the reaction: _____

_____

_____

Does your child have any severe reaction to foods or insect bites? _____

_____

Past History

Pregnancy and Birth (this child)

Age of mother at time of birth: _____

Total number of pregnancies: _____ Living children: _____ Miscarriages or stillbirths: _____

This was pregnancy number: _____

The pregnancy was: ❒ 9 months ❒ premature ❒ prolonged

Was the pregnancy complicated by: ❒ anemia ❒ bleeding ❒ high blood pressure ❒ illness or infection ❒ diabetes ❒ need for any medication

❒ Other _____

_____

Where was this child born? _____

Birth weight: _____ Length: _____

Was the delivery: ❒ breech delivery ❒ Caesarean section ❒ forceps delivery ❒ under general anesthesia (gas) ❒ difficult or prolonged

❒ Other _____

Feeding History

Breast fed _____ months. Formula fed _____ months. Name of formula: _____

Solid food began at _____ months. Table food at _____ months. Does your child eat well? _____

Are there foods your child cannot eat (list)? _____

Do you give vitamins? _____ Name(s): _____

Growth and Development

Cities in which child has lived: _____

Do parents or caretakers smoke? ❒ Yes ❒ No

Are there pets in the home/yard? _____

Does patient eat dirt, paint or other nonfood items? _____

Please list any hospitalizations, operations, injuries, or serious illnesses and the year or age they occurred:

_____

_____

_____

Immunizations

Is your child up to date? _____ (Please provide us with a copy of the immunizations.)

Hospitalizations and medical problems

Please list any hospitalizations, operations, injuries or serious illnesses, and the year they occurred: _____

_____

_____

_____

OVER