PEDIATRIC NEW PATIENT QUESTIONNAIRE
5 OR OLDER

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

List any major problems with pregnancy, delivery, newborn period: _____

_____

_____

Are your child's immunizations up to date? ❒ Yes ❒ No (Please provide us with a copy.)

Cities in which child has lived: _____

Do parents or caretakers smoke? ❒ Yes ❒ No Age at first menstrual period: _____

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.

_____

_____

_____

Family History

	Name	Age/Height/Weight	Condition of Health	Occupation
Mother				
Father				
Siblings				

Please list relationships of immediate or extended family members who have the following problems:

Allergies: _____

Asthma: _____

Blood disorders, including Sickle Cell: _____

Birth defects: _____

Bleeding problems: _____

Convulsions or epilepsy: _____

Cystic Fibrosis: _____

Diabetes (adult or childhood): _____

Heart disease in children: _____

Heart disease in adults under 55 years:

Heart attacks: _____ Hardening of the arteries: _____

Strokes: _____ Heart bypass: _____

Angina: _____

High cholesterol (over 240 or on medication): _____

High blood pressure: _____

Mental retardation: _____

Migraine headaches: _____

Thyroid disease: _____

Tuberculosis: _____

Other: _____

OVER