CHILDREN & TEENS MEDICAL CENTER

NEW PATIENT QUESTIONNAIRE *TO BE COMPLETED BY PARENT*

AGES 0 - 2 YEARS

Child's Name _____ Birthday ___ - ___ - 0_ Age _____ Today's Date _____
Father'sName _____ Occupation_____
Mother's Name _____ Occupation_____
If Mother and Father not married: Custodial parent [ ] mother [ ] father [ ] joint custody
Any court order restricting mother or father ? [ ] no [ ] yes explain_____
_____
If adults in the household work outside the home, what child care arrangements are made for this child? _____
_____

A. Pregnancy and Birth:

1. Mother's age at birth. _____
2. What was the birth weight? _____
3. Did Hheshe take any medications other than vitamins and iron? No Yes
4. Was the baby early (<38 weeks) or late (>40 weeks)? No Yes
5. Did mother have any illness during pregnancy? No Yes
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? _____
   _____
8. Any unusual findings during Pregnancy, i.e. ultrasound No Yes
9. Did child stay in hospital after mom went home? No Yes

B. Past Medical History:

1. Where has your child gone for check-ups until now and approximate date of last check-up: _____
2. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
   Which ones? _____
3. Has your child had reactions to any immunizations? No Yes
   Which ones? _____
4. Any hospitalizations other than for birth? No Yes
5. Any serious injuries? No Yes
   What kind? _____
6. Are any medications taken regularly? No Yes
   Which ones? _____

C. Family History:

1. Do the child's parents have any health problems? No Yes
2. Circle any diseases that this child's parents, grandparents brothers, sisters, or aunts and uncles have had: anemia,asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others _____
3. List age, sex, and general health of brothers and sisters
   _____
   _____
   _____
   _____
4. Have any of your children died? No Yes

D. Feeding and Nutrition:

1. Does your child have a poor appetite resulting in inactivity? No Yes
2. Do any foods disagree with him/her? No Yes
3. For the first 6 months, is he/she (was he/she) breast or bottle fed? _____
4. If still on formula, which one do you use? _____
   _____
5. Any special diet or unusual weight gain or loss? No Yes

E. Review of Systems:

1. Has your child had frequent ear infection? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child been anemic? No Yes
12. Please list any other medical problems:_____
    _____
    _____

F. Development/Behavior:

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 1 ½ years old? No Yes
4. How does this child compare to others his or her age? _____
5. Does he/she have any trouble sleeping? No Yes
6. Circle if your child has had any of the following: nail biting, thumb sucking,bedwetting, toilet training, bad temper, speech problems, hyperactivity, nightmares, problems with discipline,
   other _____
   _____

G. Safety/Environment:

1. Do you live in a private house, apartment, mobile home, other? (CIRCLE)
2. Is there a working smoke alarm on each floor in the house? No Yes
3. Does your child always use a car seat when riding in a car? No Yes
4. Are there smokers in the household? No Yes
5. Are there any problems with the condition of your home? No Yes

H. Do You Have A Record Of Immunizations? No Yes

1. Chicken pox status: Vaccinated? No Yes
2. Did child have chicken pox disease? No Yes
3. Does he/she take vitamins? No Yes

Reviewed by _____
Physician