NEW PATIENT QUESTIONNAIRE
TO BE FILLED IN BY PARENT

CHILD'S NAME _____
BIRTHDATE _____

A. PREGNANCY AND BIRTH

1. DID MOTHER HAVE ANY ILLNESS DURING PREGNANCY? YES NO
2. DID SHE TAKE ANY MEDICINE DURING PREGNANCY? YES NO
3. WAS BABY BORN ON TIME?
4. WHAT WAS BABY'S BIRTH WEIGHT? _____
5. DID BABY HAVE ANY PROBLEMS AFTER BIRTH?
   JAUNDICE, TROUBLE BREATHING, OTHER?_____

B. FEEDING AND DIGESTION

1. DID BABY HAVE ANY FEEDING PROBLEMS DURING HIS OR HER FIRST 3 MONTHS? NO YES
2. WAS HE/SHE BREAST OR BOTTLE FED? CIRCLE ANSWER
3. IS YOUR CHILD'S APPETITE USUALLY GOOD? NO YES
4. IS IT GOOD NOW? NO YES
5. DO ANY FOODS DISAGREE WITH HIM OR HER? NO YES
6. DOES HE OR SHE OFTEN HAVE DIARRHEA OR CONSTIPATION? NO YES
7. WHAT VITAMINS ARE YOU GIVING NOW? _____
8. IF STILL ON FORMULA, WHICH ONE? _____

C. PAST MEDICAL HISTORY

1. HAS YOUR CHILD HAD MORE THAN 2 EAR INFECTIONS? NO YES
2. HAS YOUR CHILD HAD MORE THAN 3 COLDS PER YEAR? NO YES
3. HAS HE OR SHE HAD ANY HEART PROBLEM? NO YES
4. ANY ASTHMA, BRONCHITIS OR PNEUMONIA? NO YES
5. HAS HE OR SHE BEEN HOSPITALIZED SINCE BIRTH? NO YES
6. ANY OPERATIONS OR SERIOUS INJURIES? NO YES
7. ANY REACTIONS TO IMMUNIZATIONS? NO YES
8. DOES HE OR SHE TAKE ANY MEDICINES REGULARLY? NO YES
9. HAS HE OR SHE ANY ALLERGIES TO MEDICINE? NO YES

D. FAMILY HISTORY

1. ARE BOTH PARENTS IN GOOD HEALTH? NO YES
2. CIRCLE ANY DISEASES HIS OR HER PARENTS OR OTHER FAMILY MEMBERS HAVE HAD:
   ALLERGY ASTHMA DIABETES HIGH BLOOD PRESSURE
   HEART DISEASE TUBERCULOSIS CONVULSIONS CANCER

3. LIST AGES, SEX AND GENERAL HEALTH OF BROTHERS AND SISTERS:

_____

_____

E. REVIEW OF SYSTEMS

1. HAS YOUR CHILD ANY EYE PROBLEMS? NO YES
2. HAS HE OR SHE PROBLEMS WITH STUFFY, SNEEZY NOSE? NO YES
3. ANY PROBLEMS WITH PERSISTENT OR NIGHT COUGH? NO YES
4. DOES HE OR SHE HAVE RECURRENT STOMACH ACHE OR UPSET STOMACH? NO YES
5. ANY PROBLEM WITH URINATING? NO YES
6. ANY PERSISTENT OR RECURRENT SKIN RASHES? NO YES
7. ANY OTHER MEDICAL PROBLEMS? _____

F. DEVELOPMENT AND BEHAVIOR

1. AT WHAT AGE DID YOR CHILD
   SIT ALONE? _____
   WALK? _____
   TALK, USING SINGLE WORDS? _____
2. HAS HE OR SHE ANY PROBLEM SLEEPING? NO YES
3. HAS HE OR SHE ANY PROBLEM IN SCHOOL? NO YES
4. DOES HE OR SHE GET ALONG WELL WITH OTHERS? NO YES
5. DOES HE OR SHE HAVE ANY PROBLEMS WITH:

   NAIL BITING THUMB SUCKING BED WETTING TOILET USE
   BAD TEMPER HYPERACTIVITY NIGHTMARES SPEECH ,
   PROBLEMS WITH DISCIPLINE IRRITABILITY
   ANYTHING THAT YOU WISH TO DISCUSS _____

   _____

PREVIOUS PEDIATRICIAN:

_____

SIGNATURE OF PARENT _____