

Western Wake Pediatrics, PA

New Patient Questionnaire

Name _____ DOB _____ Chart # _____

Person Filling Out This Form? (circle): Mother Father Other: _____

Mother's Name: _____ Age _____

Father's Name: _____ Age _____

If adults in the household work outside the home, what child care arrangements are made for this child?

Please circle one. If YES, please explain in the lines provided to the right.

A. PREGNANCY AND BIRTH:

1. Mother's age at birth: _____
2. Did mother have any illness during pregnancy? No Yes _____
3. Did she take any medications other than vitamins & iron? No Yes _____
4. Alcohol? No Yes _____
5. Cigarette use? No Yes _____
6. Marijuana / Drugs? No Yes _____
7. History of herpes, HIV, or other genital infections? No Yes _____
8. What was your due date? _____
9. Vaginal or cesarean? _____
10. If cesarean Why? _____
11. What was the birth weight? _____
12. Did the baby have any trouble starting to breathe? No Yes _____
13. Did the baby have any trouble while in the hospital?
(jaundice, infections, other?) No Yes _____

B. PAST MEDICAL HISTORY

1. Any serious past medical problems? No Yes _____
2. Any past surgery (including ear tubes)? No Yes _____
3. Date of last checkup: _____
4. Date of last dental checkup: _____
5. Has your child had allergic reactions to any medications,
foods, insect bites? No Yes _____
6. Has your child had reactions to any immunizations? No Yes _____
7. Any hospitalizations other than for birth? No Yes _____
8. Any serious injuries? No Yes _____
9. Take medications regularly? No Yes _____
10. Alternative medicine / Herbal remedies? No Yes _____

C. FAMILY HISTORY

1. Are the child's parents both in good health? No Yes _____
2. Please indicate if mother (M), father (F), siblings (S), grandparent
(GF, GM, ect.) have had any of the following:

Arthritis _____
High cholesterol _____
High Blood Pressure _____
Stroke _____
Diabetes _____
Kidney disease _____
Alcoholism _____
Drug abuse _____
AIDS _____
Hepatitis _____
Tuberculosis _____

Allergy (type) _____
Inherited/ genetic _____
Cystic fibrosis _____
Sickle cell _____
Hemophilia _____
Seizures _____
Emotional problems _____
Obesity _____
Birth defect _____
Cancer _____

Signature _____ Date _____

First Name: _____

Chart # _____

Please circle one. If YES, please explain in the lines provided to the right.

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. Is your child's appetite usually good? No Yes _____

2. Is it good now? No Yes _____

3. Was there sever colic or any unusual feeding problems? No Yes _____

4. Do any foods disagree with him/her? No Yes _____

5. For the first 6 months, did you breast or bottle feed? _____

Which do you use now (note brand of formula) _____

6. Does he/she take vitamins? No Yes _____

7. Any herbal supplements? No Yes _____

E. REVIEW OF SYSTEMS

1. Has your child had any of the following? _____

Frequent ear infections? No Yes _____

Hearing problems? No Yes _____

Eye problems? No Yes _____

Problems with teeth? No Yes _____

Frequent colds or sore throats? No Yes _____

Asthma, pneumonia, or recurrent cough? No Yes _____

Heart murmur or any hear problems? No Yes _____

Problems with urination? No Yes _____

Diarrhea or constipation? No Yes _____

Convulsions or other central nervous system problems? No Yes _____

Eczema, hives or other skin conditions? No Yes _____

2. Please note any other medical problems: _____

F. DEVELOPMENT/BEHAVIOR

1. Age your child sat alone? _____ mo. _____

2. At what age did he/she walk alone? _____ mo. _____

3. Did he/she say any words by 1 1/2 years of age? No Yes _____

4. How does this child compare to others his/her age? _____

5. Any trouble sleeping? No Yes _____

6. Grade in school? _____

7. Trouble getting along well with other children? No Yes _____

8. Circle if your child has any of the following: _____

nail biting _____ nightmares/ sleep problems _____

thumb sucking _____ speech problems _____

bedwetting _____ discipline problems _____

problems with toilet training _____ bad temper _____

hyperactivity _____ other (explain) _____

G. SAFETY/ENVIRONMENT

1. Do you live in a private house, apartment, mobile home, other (circle one) _____

2. Do you know the hottest temperature of the water in your house? No Yes _____

3. Is there a working smoke alarm on each floor in your house? No Yes _____

4. Does your child always use a car seat/seat belt when riding in a car? No Yes _____

5. Are any smokers in the house? No Yes _____

6. Are there any problems with the condition of your home? (peeling paint, insects, rats, etc.) No Yes _____

7. Does your child always wear a helmet when riding a bicycle, scooter, skateboard, rollerblading or skating? No Yes _____

8. Are parents: (circle one) Married Divorced Separated Widowed _____

9. With whom and where does the child reside? _____

Signature _____ Date _____