

# Western Wake Pediatrics & Adolescent Medicine

## 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), maternal or paternal grandparent  
(MGF, MGM, PGF, PGM.) have had any of the following:

Arthritis	_____	Allergy (type)	_____
High cholesterol	_____	Inherited/ genetic	_____
High Blood Pressure	_____	Cystic fibrosis	_____
Stroke	_____	Sickle cell	_____
Diabetes	_____	Hemophilia	_____
Kidney disease	_____	Seizures	_____
Alcoholism	_____	Emotional problems	_____
Drug abuse	_____	Obesity	_____
AIDS	_____	Birth defect	_____
Hepatitis	_____	Cancer	_____
Tuberculosis	_____		

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 bed 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 \_\_\_\_\_