PEDIATRIC NEW PATIENT QUESTIONNIER

Name ______________________________

Date of Birth ______________________________

Today's Date:______________________________

Dear Parents,

Please describe briefly the main problem that brings you here today with your child:

____

Review of System:

	No		Yes	Eye or vision problems
	No		Yes	Ear problem/ ear infections
	No		Yes	Throat/tonsil problems
	No		Yes	Does the child snore during sleep?
	No		Yes	Sleep apnea
	No		Yes	Thyroid or other gland problems
	No		Yes	Heart problems such as murmurs or chest pain
	No		Yes	Stomach or intestinal problems/diarrhea/constipation
	No		Yes	Genital or urinary problems
	No		Yes	Bone problems
	No		Yes	Muscle problems
	No		Yes	Neurological/seizure/developmental delay
	No		Yes	Skin problems/rashes
	No		Yes	General symptoms (fever, lethargy, weight change, appetite change)
	No		Yes	Cough/ Wheeze/ Shortness of Breath

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Date of Birth __________________________

Today's Date:_________________________

Past Medical History

Birth weight______ (lbs.) _________ (Oz's) Was child born prematurely? ___Yes ___No

Has your child ever been hospitalized? _____Yes _____No. If yes, reason_________________________

Has your child ever had surgery? _____Yes ____No. If yes, reason_____________________________

Please list any specialist your child has seen: ____

Please list any tests your child has had: ____

Family History

Mother's age _____. Any medical problems____

Father's age _____. Any medical problems____

Please list brother and sisters:

Name	Age	Name	Age
______________________	__________	___________________________	_________
______________________	__________	___________________________	_________

Please list any medical problems____

Social History

Who has legal custody of child? ____________________ Relationship __________________

Lit smokers in the household: ___ none ____Mother ____Father ____Other

List pets (indoor or outdoor) ____

Does the child attend ____school ____ daycare ____ home schooled

Please list any family issues that we should be aware of_______________________________

Parent/Patient/Legal Guardian Signature: _________________Date:________Time:___

Reviewed by: ______________________________________ Date:________Time:___

(Provider)