New Patient Questionnaire 2-18 Years Owensboro Pediatrics

Child's Name:_____ **Gender:** ☐MALE ☐FEMALE
FIRST MIDDLE LAST

Date Of Birth:_____/_____/_____ What do you call your child (nickname)?_____

Mother's Name:_____Age:_____Occupation:_____

Father's Name:_____Age:_____Occupation:_____

Parents are: ☐Married ☐Single ☐Separated ☐Divorced ☐Remarried

Names of other Children at home:_____

Previous Doctor for your child:_____

Where did your child get immunizations (baby shots)?_____

Pregnancy And Birth	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**
1. Were there any problems during the pregnancy with this child? _____ _____	☐	☐	
2. Did the mother smoke during the pregnancy?	☐	☐	
3. Did the mother use **any** alcohol, drugs, or medication during the pregnancy?	☐	☐	
4. Did the baby come more than 2 weeks early or 2 weeks late?	☐	☐	
5. Where was this child born?			
6. What was the baby's birth weight?			
7. Were there any problems during labor or delivery? _____ _____ Delivery was: Vaginal ☐ C-Section ☐	☐	☐	
8. Were there any problems during the nursery stay? _____ _____	☐	☐	
Diet and Nutrition	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**
9. Is your child's appetite usually good?	☐	☐	
10. Is it good now?	☐	☐	
11. Was there severe colic or any unusual feeding problem during the first three months?	☐	☐	
12. Do any foods "disagree" with your child? Please list: _____	☐	☐	
13. Does your drinking water have fluoride in it?	☐	☐	
14. How many meals does your child eat a day?			
Diet and Nutrition, Continued	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**

15. Does the child ever eat dirt, plaster, or paint?	☐	☐	
16. Does the child take vitamins, fluoride, iron, or other supplements?	☐	☐	
Review of Systems			
17. Has your child had frequent ear infections?	☐	☐	
18. Any eye problems?	☐	☐	
19. Any problems with the teeth?	☐	☐	
20. Frequent colds or sore throats?	☐	☐	
21. Is there asthma, pneumonia, or recurrent cough?	☐	☐	
22. Does your child have a heart murmur or any heart problems?	☐	☐	
23. Any problems with urination or bedwetting?	☐	☐	
24. Have there been any problems with diarrhea, constipation, or trouble controlling bowel movements?	☐	☐	
25. Have there been any convulsions, recurring headaches or other problems with the nervous system?	☐	☐	
26. Any eczema, hives, or other skin conditions?	☐	☐	
27. Has your child ever been anemic?	☐	☐	
28. Has you child ever been admitted to a hospital? Please list: _____ _____	☐	☐	
29. Has your child ever had surgery? If yes, please list: _____ _____	☐	☐	
30. List any medicines your child takes: _____ _____	☐	☐	
31. Is your child allergic to any medicines? Please list them: _____	☐	☐	
Development and Behavior	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**
32. Did child sit alone by 7 months?	☐	☐	
33. Did the child walk alone by 14 months?	☐	☐	
34. Did the child say 3 words by 15 months?	☐	☐	
35. Was your child toilet trained by age 3?	☐	☐	
36. Where does your child go to daycare or school?			
37. Is the child doing well in school? What grade is your child in?_____	☐	☐	
Development and Behavior, Continued	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**

38. Does your child get along well with other children?	☐	☐	
39. Do you have rules/limits for television viewing?	☐	☐	
40. Does your child have regular chores to do?	☐	☐	
41. Does your child get an allowance?	☐	☐	
42. Check off any of the following problems which the child has ☐ Nightmares/Sleep problems ☐ Irritable/Bad Temper ☐ Speech Problems ☐ Toilet Training Problems ☐ Discipline Problems ☐ Bed Wetting ☐ School Problems ☐ Depression			
Health and Safety Issues	**YES**	**NO**	**COMMENTS (OFFICE USE ONLY)**
43. Do you live in a ☐ private house, ☐ Apartment, ☐ Mobile home, ☐ Other?			
44. Do you know the hottest temperature of the water in your pipes?	☐	☐	
45. Is there a working smoke alarm on each floor in the house?	☐	☐	
46. Does your child always use a car seat or seat belt when riding in the car?	☐	☐	
47. Are there any smokers in the household?	☐	☐	
48. Are there any guns in the household?	☐	☐	
49. If yes, are they kept unloaded and locked up?	☐	☐	
50. Does your child always wear a helmet when riding a bicycle or rollerblading?	☐	☐	
51. Are medicines and potential poisons out of reach?	☐	☐	
52. Do you have syrup of Ipecac in the house?	☐	☐	
53. Does your child know how to swim?	☐	☐	
54. Does the child use a toothbrush daily?	☐	☐	
55. Does your child see a dentist regularly? Dentist's Name:	☐	☐	
56. Who takes care of your child after school or if parents are unavailable?			
Family History			**COMMENTS (FOR OFFICE USE ONLY)**
57. Please mark any illnesses that run in your family: ☐ High Blood Pressure ☐ Cancer ☐ Diabetes ☐ Asthma/Allergies ☐ Heart Disease or heart attacks before age 50 ☐ High Cholesterol ☐ Sickle Cell Disease ☐ Sickle Cell Disease ☐ Mental Illness ☐ Other:_____			
58. Please list any concerns that you would like to discuss with the doctor: _____ _____			