# New Patient Questionnaire - Newborn Owensboro Pediatrics

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

Today's Date:_____/_____/_____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:_____

Has your child had any 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. Who delivered the baby? | | | |
| 8. Were there any problems during labor or delivery? _____ _____ Delivery was: Vaginal ☐ C-Section ☐ | ☐ | ☐ | |
| 9. Were there any problems during the nursery stay? _____ _____ | ☐ | ☐ | |
| **Review of Systems** | **YES** | **NO** | **COMMENTS ( OFFICE USE ONLY)** |
| 10. Is your child's appetite usually good? | ☐ | ☐ | |
| 11. Does your baby have severe colic or any feeding problem? | ☐ | ☐ | |
| 12. Was/is this child breast fed? | ☐ | ☐ | |
| If discontinued, when? | | | |
| 13. If on formula, which one do you use? | | | |
| 14. Any breathing problems? | ☐ | ☐ | |
| 15. Any eye problems? | ☐ | ☐ | |

| Review of Systems, Continued | YES | NO | COMMENTS ( OFFICE USE ONLY) |
|---|---|---|---|
| 16. Does your child have a heart murmur or any heart problems? | ☐ | ☐ | |
| 17. Any problems with urination? | ☐ | ☐ | |
| 18. Have there been any problems with bowel movements? | ☐ | ☐ | |
| 19. Have there been any convulsions or other problems with the nervous system? | ☐ | ☐ | |
| 20. Any skin problems? | ☐ | ☐ | |
| 21 List any medicines your child uses: (include vitamins) _____ | ☐ | ☐ | |
| 22. Is your child allergic to any medicines? Please list them: _____ | ☐ | ☐ | |
| **Health and Safety Issues** | **YES** | **NO** | **COMMENTS (OFFICE USE ONLY)** |
| 23. Do you live in a ☐ private house, ☐ Apartment, ☐ Mobile home, ☐ Other? | | | |
| 24. Do you know the hottest temperature of the water in your pipes? | ☐ | ☐ | |
| 25. Do you have ☐ city water or ☐ well water? | | | |
| 26. Does your drinking water have fluoride in it? | ☐ | ☐ | |
| 27. Is there a working smoke alarm on each floor in the house? | ☐ | ☐ | |
| 28. Does your child always use a car seat when riding in the car? | ☐ | ☐ | |
| 29. Are there any smokers in the household? | ☐ | ☐ | |
| 30. Are there any guns in the household? | ☐ | ☐ | |
| 31. If yes, are they kept unloaded and locked up? | ☐ | ☐ | |
| 32. Are medicines and potential poisons out of reach? | ☐ | ☐ | |
| 33. Do you have syrup of Ipecac in the house? | ☐ | ☐ | |
| 34. Who takes care of your child during the day? | | | |

| Family History | COMMENTS (OFFICE USE ONLY) |
|---|---|
| 35. Please mark any illnesses that run in your family:<br>☐ High Blood Pressure ☐ Cancer<br>☐ Diabetes ☐ Asthma/Allergies<br>☐ Heart Disease or heart attacks before age 50<br>☐ High Cholesterol ☐ Sickle Cell Disease<br>☐ Sickle Cell Disease ☐ Mental Illness<br>☐ Other:_____ | |
| 36. Please list any concerns that you would like to discuss with the doctor:<br>_____<br>_____<br>_____<br>_____ | |