# New Patient Questionnaire Birth-2 years Owensboro Pediatrics

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

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

Mother's First & Last Name:__________________________________________Age:______Occupation:________________________________

Father's First & Last 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?<br>____________________<br>____________________ | | | |
| 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?<br>____________________<br>____________________<br>Delivery was: Vaginal C-Section | | | |
| 8. Were there any problems during the nursery stay?<br>____________________<br>____________________ | | | |
| **Feeding and Digestion** | **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? | | | |
| 13. Was/is this child breast fed? | | | |
| If discontinued, when? | | | |
| 14. If still on formula, which one do you use? | | | |

| Review of Systems | YES | NO | COMMENTS (OFFICE USE ONLY) |
|---|---|---|---|
| 15. Has your child had frequent ear infections? | | | |
| 16. Any eye problems? | | | |
| 17. Any problems with the teeth? | | | |
| 18. Frequent colds or sore throats? | | | |
| 19. Is there asthma, pneumonia, or recurrent cough? | | | |
| 20. Does your child have a heart murmur or any heart problems? | | | |
| 21. Any problems with urination? | | | |
| 22. Have there been any problems with diarrhea or constipation? | | | |
| 23. Have there been any convulsions or other problems with the nervous system? | | | |
| 24. Any eczema, hives, or other skin conditions? | | | |
| 25. Has your child ever been anemic? | | | |
| 26. Has you child ever been admitted to a hospital? Please list:<br>______________________________<br>______________________________ | | | |
| 27. Has your child ever had surgery? If yes, please list:<br>______________________________<br>______________________________ | | | |
| 28 List any medicines your child takes: (include vitamins)<br>______________________________<br>______________________________ | | | |
| 29. Is your child allergic to any medicines? Please list them:<br>______________________________<br>______________________________ | | | |
| **Development and Behavior** | **YES** | **NO** | **COMMENTS (OFFICE USE ONLY)** |
| 30. Did your child roll over by 5 months? | | | |
| 31. Did your child sit up by 7 months?? | | | |
| 32. Did your child crawl on hands and knees by 9 months? | | | |
| 33. Did your child say "mama" by 12 months? | | | |
| 34. Did your child walk alone by 15 months? | | | |
| 35. Is your child interested in potty training? | | | |
| 36. Does your child know how to use a spoon or fork to eat? | | | |
| 37. Does your child fall asleep in his/her own bed? | | | |
| 38. Does your child sleep all night? | | | |

| Health and Safety Issues | YES | NO | COMMENTS (OFFICE USE ONLY) |
|---|---|---|---|
| 39. Do you live in a private house, Apartment, Mobile home, Other? | | | |
| 40. Do you know the hottest temperature of the water in your pipes? | | | |
| 41. Do you have city water or well water? | | | |
| 42. Does your drinking water have fluoride in it? | | | |
| 43. Is there a working smoke alarm on each floor in the house? | | | |
| 44. Does your child always use a car seat when riding in the car? | | | |
| 45. Are there any smokers in the household? | | | |
| 46. Are there any guns in the household? | | | |
| 47. If yes, are they kept unloaded and locked up? | | | |
| 48. Are medicines and potential poisons out of reach? | | | |
| 49. Do you have syrup of Ipecac in the house? | | | |
| 50. Does the child use a toothbrush daily? | | | |
| 51. Does your child see a dentist regularly?<br>Dentist's Name: | | | |
| 52. Who takes care of your child during the day? | | | |

| Family History | COMMENTS (OFFICE USE ONLY) |
|---|---|
| 53. 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:_______________________________________________ | |
| 54. Please list any concerns that you would like to discuss with the doctor:<br>______________________________________________________________________________<br>______________________________________________________________________________<br>______________________________________________________________________________<br>______________________________________________________________________________ | |