SIMI PEDIATRIC PARTNERS

NEW PATIENT QUESTIONNAIRE
TO BE FILLED OUT BY PARENT

Mother's Name _____ Age_____
Occupation _____
Father's Name _____ Age _____
Occupation _____
If adults in the household work outside the home, what childcare arrangements are made for this child?
_____

Patient's Name _____

Date _____

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 meds other than MVI and iron? No Yes
4. Was the baby on time? Yes No
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other)? No Yes

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups until now?
_____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
Which ones? _____
5. Has your child had reactions to any vaccines? No Yes
Which ones? _____
6. Any hospitalizations other than for birth? No Yes
For what? _____
7. Any serious injuries? No Yes
What kind? _____
8. Are any medications taken regularly? No Yes
Which ones? _____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? Yes No
2. Circle any disease that this child's parents, grandparents, brothers, sisters, or aunts/uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug/alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex, and general health of siblings: _____
_____
_____
4. Have any of your children died? No Yes

D. FEEDING AND NUTRITION

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? _____
6. If still on formula, which one do you use?
_____
7. Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throat? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur/heart problem? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems: _____
_____
_____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was 1 ½ years old? Yes No
4. How does this child compare to others of his/her age?
_____
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No Yes
8. Does he/she get along with other children? Yes No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, hyperactivity, problems toilet training, bad temper, nightmares, speech problems, problems with discipline, others

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice)? No Yes
7. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF VACCINES?

Yes No