

FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT

Mother's name _____ Age _____

Occupation _____

Father's name _____ Age _____

Occupation _____

Who lives with child in the home? _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____

CHILD'S NAME _____

DOB: _____

DATE: _____

A. PREGNANCY AND BIRTH:

- 1. Mother's age at child's birth? _____
- 2. Did mother have any illness during pregnancy? No Yes
- 3. Did she take any medications other than vitamins and iron? No Yes
- 4. Was the baby on time? Yes No
- 5. What was the birthweight? _____
- 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
What kind? _____

B. PAST MEDICAL HISTORY:

- 1. Where has your child gone for checkups 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 immunizations? 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 diseases that this child's parents, grandparents, brothers, sisters or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, migraine, others
- 3. List age, sex, and general health of brothers and sisters _____
- 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 throats? No Yes
- 5. Is there asthma, pneumonia, or recurrent cough? No Yes
- 6. Does he/she have a heart murmur or any heart problems? 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. Is child seeing any other doctor or therapist? No Yes
- 13. 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 1½ years old? Yes No
- 4. How does this child compare to others his or 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, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others

G. SAFETY/ENVIRONMENT:

- 1. Is there a working smoke alarm on each floor in the house? Yes No
- 2. Does your child always use a car seat/seat belt when riding in a car? Yes No
- 3. Are there any smokers in the household? No Yes
- 4. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

I. IF YOU HAVE SPECIFIC QUESTIONS OR CONCERNS FOR THE DOCTOR PLEASE WRITE THEM DOWN ON THE BACK OF THIS SHEET.