Who is your child’s pediatrician?

Who referred your child to see us?

**HISTORY OF PRESENT ILLNESS:**

Reason for visit:

When did the problem(s) start?

Does anything make it better or worse?

Any other associated symptoms?

Please list your child’s allergies, including any allergies to medication:

What medication is your child taking now? (regularly and only as needed). Please include **ALL** prescriptions, over the counter medications, vitamins, herbs, and complementary or alternative medications:

List any surgeries and the approximate dates:

List any hospitalizations (not including trips to the Emergency Room):

Are your child’s immunizations current?  □ Yes  □ No

**BIRTH HISTORY:**

Was your child born on time, early, or late?  ____________  Birth Weight:  ____________

Problems during the pregnancy:

Did your child have any problems since birth (heart murmur, hearing loss, etc.)?

**SOCIAL HISTORY:**

How many siblings does your child have?  ____________  What grade is your child in?  ____________

Is your child in daycare?  ____________  If yes, how many children are in the daycare?

Is your child exposed to any type of smoke?  ____________  Do you smoke?  □ Yes  □ No

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NEW PATIENT QUESTIONNAIRE

ACCOUNT NO. MED. REC. NO.
NAME:
BIRTHDATE:

Patient Identification

REVIEW OF SYSTEMS:
Does your child have a problem with any of the following, either now or in the past? (If yes, please explain):

Fevers or Weight Loss

Eyes or Vision

Skin

Heart, Blood Vessels, Lungs

Urinary Tract (bladder), Kidneys

Digestive Tract

Muscles or Bones

Nerves or Behavior

Immune System

Anemia, Bleeding, Clotting

FAMILY HISTORY:
Does anyone on either side of the family (excluding the patient) have any of the following conditions? If yes, who in the family has the problem?

Chronic Ear Infections Yes / No

Hearing Loss (especially before the age of 20) Yes / No

Blindness (especially before the age of 20) Yes / No

Cleft Lip and / or Cleft Palate Yes / No

Allergies (“hay fever”) Yes / No

Asthma Yes / No

Bleeding Problems Yes / No

Problems with Anesthesia Yes / No

Any other medical conditions that run in the family Yes / No

Completed by: _______________________________ Date: __________________

If completed by someone other than the patient, what is your relationship to the patient? __________________

FOR OFFICE USE ONLY

Reviewed by _______________________________ Date: __________________

Comments: ________________________________

** Please keep this questionnaire with you until you see the doctor **

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