



NEW PATIENT QUESTIONNAIRE

ACCOUNT NO.
MED. REC. NO.
NAME
BIRTHDATE

Patient Identification

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: _____

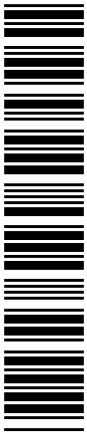
Did your child have any problems since birth (heart murmur, hearing loss, etc.)? _____

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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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 ****