Professional Association for Pediatrics – 1850 Hickory Street, Suite #102 – Abilene, Texas 79601

New Patient Health Questionnaire

Patient's Name _____ Date: _____
Mother's Name _____ Age: _____ Father's Name_____ Age: ____
If adults in the household work outside the home, what child care arrangements are made for this child? _____

A. PREGNANCY AND BIRTH:

1. Mother's age at patient's birth _____
2. Did mother have any illness during pregnancy? Y N
3. Did she take any medications other than Vitamins and iron? Y N
4. Was the baby on time? Y N
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breathe? Y N
7. Did the baby have any trouble while in the hospital? (Jaundice, infections, other?) Y N
   What kind?_____
   _____

B. PAST MEDICAL HISTORY:

1. Where has you child gone for check-up 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? Y N
   Which ones? _____
5. Has your child had reactions to any Immunizations? Y N
   Which ones? _____
6. Any hospitalizations other than for birth? Y N
   For what? _____
7. Any serious injuries? Y N
   What kind? _____
8. Are any medications taken regularly? Y N
   Which ones? _____

C. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Y N
2. Is it good now? Y N
3. Was there severe colic or any unusual feeding problem during the first 3 months? Y N
4. Do any foods disagree with him/her? Y N
5. For the first 6 months is he/she (was he/she) breast-fed or bottle-fed? _____
6. If still on formula, which one? _____
7. Does he/she take vitamins? Y N

D. REVIEW OF SYSTEMS:

1. Any ear trouble or hearing loss? Y N
2. Any eye problems? Y N
3. Has child had any problems with teeth/gums? Y N
4. Does child have frequent colds/sore throats? Y N
5. Is there asthma/pneumonia/recurrent cough? Y N
6. Does child have a heart murmur or any heart problems? Y N
7. Does child have any problems with urination? Y N
8. Does child have any problems with diarrhea or or constipation? Y N
9. Have there been any convulsions or other problems with the nervous system? Y N
10. Any eczema, hives, other skin conditions? Y N
11. Has child ever been anemic? Y N
12. Please list any other medical problems:
    _____
    _____

E. DEVELOPMENT / BEHAVIOR:

1. At what age did child sit alone? _____

2. At what age did child walk alone? _____

3. Did child say any words by the time he/she Was 1 ½ years old? Y N

4. How does child compare to others same age? _____

5. Does child have any trouble sleeping? Y N

6. What grade is child in? _____

7. Has child had any trouble in school? Y N

8. Does child get along with other children? Y N

9. Does child have any of the following? Y N

____ Thumb sucking ____ Nail biting

____ Bed Wetting ____ Bad temper

____ Problems with toilet training ____ Hyperactivity

____ Problems with discipline ____ Nightmares

____ Speech problems ____ Other

F. SAFETY / ENIRONMENT:

1. Do you live in a:

____ Private house ____ Apartment

____ Mobile home ____ Other:_____

2. Do you know the hottest temperature of the Water in your pipes? Y N

3. Is there a working smoke alarm on each floor in the house? Y N

4. Does your child always us a car seat / Seat belt when riding in the car? Y N

5. Are there any smokers in the household? Y N

6. Are there any problems with the condition of your home (peeling paint, insects, rats or mice? Y N

7. Does your child always wear a helmet when Riding his / her bicycle or rollerblading? Y N

G. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Y N

H. FAMILY HISTORY:

(mark if present in any of your child's, siblings, aunts/uncles, first cousins, or grandparents)

____ Spina Bifida ____ Vision/eye problems

____ Bone disorder ____ Cerebral Palsy

____ Cleft lip/palate ____ ADD / learning disorder

____ Hearing loss/deafness ____ Convulsions

____ Heart disease/defect ____ Infertility

____ Neurofibromatosis ____ Limb defects

____ Mental retardation ____ Down Syndrome

____ Neurological disorder ____ Cystic fibrosis

____ Mental illness ____ Short stature (< 5ft)

____ Tuberculosis ____ Diabetes

____ Hay fever/allergies ____ Drug/alcohol problems

____ Sickle Cell anemia ____ Bleeding disorder

____ Muscle disorder ____ Kidney disease

____ Skin disease ____ Genital abnormality

____ High blood pressure ____ Asthma

____ Urinary tract abnormality ____ AIDS (HIV)

____ High cholesterol/triglycerides

____ Chromosome abnormality

____ Brain anomalies (includes Hydrocephaly)

____ Anemia (includes Thalassemia)

____ Patient's mother was exposed to DES

____ Other birth defect / malformations / problems?

Please list: _____
_____

List age, sex, and health problems of siblings (are they living)?
_____
_____

Reviewed by _____
Date _____