Associated Physicians, LLP

Date: _______________

New Patient Questionnaire

Child's Name__________________________ Present Age _____ Birth date _______________

If child is 6 years or older, skip to Infectious Disease Section

Yes No Did mother have any health problems during pregnancy?__________________________
Yes No Was delivery other than vaginal and head first?__________________________________
Yes No Did baby need help to start breathing?_______________________________________
Yes No Were there any physical abnormalities at birth?_________________________________
Yes No Were there any problems in the nursery (i.e. yellow jaundice)?_____________________
Yes No Was the child adopted? Age of adoption____

Growth & Development

Birth Weight _______________ Birth Length _______________
Yes No Was the baby breast fed? If so, how long?___________________
If formula fed, which kind? _______________________________
Yes No Did baby have any feeding problems?
Solids started around _____ months of age.

Other known measurements:
Age _______________ Weight _______________ Height _______________
Age _______________ Weight _______________ Height _______________
Age _______________ Weight _______________ Height _______________

Milestones:
Smiled _____ months of age
Sat alone _____ months of age
Walked alone _____ months of age
Said single words at _____ months of age
Spoke in 2 word phrases at _____ months of age
Spoke in 3 word sentences at _____ months of age

Infectious Disease

Please write the age your child was when she/he had the disease.

Chicken Pox ____
Ear Infections ____
Strep Throat ____
Pneumonia____
Asthma ____
Exposure to Tuberculosis ____

Past Medical History

Have there been any problems with weight gain, growth or development?_________________________
Has your child been hospitalized? Please give date and reason. ___________________________________
Have there been any significant medical illnesses? ____
Does she/he have any known allergies to medication or other substances? _________________________
Is she/he taking any medications now? ____
Has she/he had any head injuries or broken bones? ____

Family History

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Please indicate which of the CHILD's blood relatives have had the follow conditions
M=Mother, F=Father, S=Sister, B=Brother, GM =grandmother, GF = grandfather, U=Uncle, A=Aunt
indicate maternal or paternal with an M or P.

___ Allergy (hay fever, asthma, eczema, drugs)
___ Eye problems
___ Hearing problems
___ Heart disease (infancy/childhood)
___ Heart attack, angina or stroke before age 50
___ High cholesterol
___ Tuberculosis
___ Cystic Fibrosis
___ Ulcers or colitis
___ Kidney problems
___ Scoliosis
___ Intellectual disabilities
___ Seizures
___ Attention deficit disorder or hyperactivity
___ Emotional problems
___ Diabetes
___ Thyroid disorders
___ Cancer
___ Anemia or bleeding disorders
___ Birth defects (cleft palate, spina bifida, etc.)
___ Other

Review of Systems

Does your child have the following symptoms?

___ Frequent headaches
___ Eye or vision problems
___ Ear or hearing problems
___ Frequent runny nose or nasal congestion
___ Frequent cough or wheezing
___ Shortness of breath/easy tiring with exercise
___ Frequent stomachaches or constipation
___ Painful or frequent urination
___ Limp
___ Rash
___ Weak urinary stream
___ Excessive bleeding from cuts
___ Toeing in or out when walking
___ Joint swelling, redness, warmth, soreness
___ Frequent wet pants over age 3 years
___ Leakage of stool or bowel accidents over age 3 years

Behavior

Compared to other children, does your child seem to have these symptoms?

___ Difficulty getting to sleep
___ Frequent nightmares
___ Short attention span
___ Seems unusually clumsy
___ Speech difficulties
___ Twitches or tics
___ Excessive thumb sucking
___ Excessive temper tantrums
___ Breath holding spells
___ Extremely outgoing
___ Extremely shy
___ Trouble playing with other children

Health Practices

Does your child use a car seat or seat belt at all times? _____ Which type?___________________________
Do any family members smoke? _____ Do you have functioning smoke detectors in your home? _____
Does your hot water temperature at home exceed 130 degrees? _____

Do you have any other concerns regarding your child's health?

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