Patient Questionnaire

Please check Yes☐ No☐ and explain where required. N/A = Not Applicable

Previous **Medical care** was with Dr. **Dental care** Yes☐ No☐ **Eye Exam** Yes☐ No☐

Pregnancy & Birth

Mother's age at pregnancy?

Any illness during pregnancy? Yes☐ No☐

Medications during pregnancy? Yes☐ No☐

Smoking - Alcohol - Street drugs - during pregnancy? Yes☐ No☐

Was baby early - late - on time?

Type of delivery? Birth weight Length

Complications? Yes☐ No☐ APGAR

Problems with the baby at birth? Breathing Yes☐ No☐ Jaundice Yes☐ No☐

Other problems

Problems soon after? At nursery or at home?

Feeding & Nutrition

Food Allergies

Appetite usually good Y☐ N☐

Colic or feeding problems during the first 3 months Y☐ N☐

Breast fed? Y☐ N☐ Numbers of months

Formula Y☐ N☐ Current brand

Vitamins? Y☐ N☐ Brand Fluoride Y☐ N☐

Family Profile

Parents -
Married? ☐ Separated ☐ Divorced? ☐
Father's age?
Highest school grade?
Health?
Mother's age?
Highest school grade?
Health?
List child's brothers, sisters & ages-

Family Medical History

List all blood relatives of your child who have had the following problems - use abbreviations F-Father, M-Mother, B-Brother, S-Sister, MM-Mother's mother, MF-Mother's father, FM-Father's mother, FF-Father's father, A-Aunt, U-Uncle, C-Cousin.

Aids	Sudden Infant Death
Cancer	High Blood Pressure
Asthma	Cholesterol Problem
Arthritis	Muscular Dystrophy
Diabetes	Mental Retardation
Migraine	Anemia/Blood Dis
Alcoholism	Epilepsy/Seizures
Birth Defects	Early Deafness
Tuberculosis	Cystic Fibrosis
Heart Disease	Drug Problem