

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 <input type="checkbox"/> No <input type="checkbox"/>	
Medications during pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Smoking - Alcohol - Street drugs - during pregnancy? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Was baby early - late - on time? _____	
Type of delivery? _____	Birth weight _____
Complications? Yes <input type="checkbox"/> No <input type="checkbox"/>	
APGAR _____	
Problems with the baby at birth? Breathing Yes <input type="checkbox"/> No <input type="checkbox"/> Jaundice Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other problems _____	
Problems soon after? _____	At nursery or at home? _____

Family Profile
Parents - Married? <input type="checkbox"/> Separated <input type="checkbox"/> Divorced? <input type="checkbox"/>
Father's age? _____
Highest school grade? _____
Health? _____
Mother's age? _____
Highest school grade? _____
Health? _____
List child's brothers, sisters & ages- _____

Past Medical History	
Have you ever had any allergic reactions to the following:	
Medicine Y <input type="checkbox"/> N <input type="checkbox"/> Food Y <input type="checkbox"/> N <input type="checkbox"/> Animals Y <input type="checkbox"/> N <input type="checkbox"/> Insects bites Y <input type="checkbox"/> N <input type="checkbox"/> If yes, list-	
1. _____	
2. _____	
Medications taken on a regular basis? (excludes vitamins) _____	
Immunizations up to date? Yes <input type="checkbox"/> No <input type="checkbox"/> Do you have a record with you? Yes <input type="checkbox"/> No <input type="checkbox"/>	
Hospitalizations - Yes <input type="checkbox"/> No <input type="checkbox"/> (when-where-why?) If yes, list-	
1. _____	3. _____
2. _____	4. _____
Surgeries - Yes <input type="checkbox"/> No <input type="checkbox"/> (when-where-why?) If yes, list-	
1. _____	3. _____
2. _____	4. _____
Serious injuries (when-where?) _____	

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

Problems with Hearing Y <input type="checkbox"/> N <input type="checkbox"/>	Whooping Cough Y <input type="checkbox"/> N <input type="checkbox"/>	Scarlet Fever Y <input type="checkbox"/> N <input type="checkbox"/>
German Measles (3 day) Y <input type="checkbox"/> N <input type="checkbox"/>	Rheumatic Fever Y <input type="checkbox"/> N <input type="checkbox"/>	Chicken Pox Y <input type="checkbox"/> N <input type="checkbox"/>
Problems with Vision Y <input type="checkbox"/> N <input type="checkbox"/>	Joint Problems Y <input type="checkbox"/> N <input type="checkbox"/>	Hepatitis Y <input type="checkbox"/> N <input type="checkbox"/>
Bleeding Tendency Y <input type="checkbox"/> N <input type="checkbox"/>	Eczema/Hives Y <input type="checkbox"/> N <input type="checkbox"/>	Seizures Y <input type="checkbox"/> N <input type="checkbox"/>
Blood Transfusions Y <input type="checkbox"/> N <input type="checkbox"/>	Strep Throat Y <input type="checkbox"/> N <input type="checkbox"/>	Anemia Y <input type="checkbox"/> N <input type="checkbox"/>
Asthma/Wheezing Y <input type="checkbox"/> N <input type="checkbox"/>	Ear Infections Y <input type="checkbox"/> N <input type="checkbox"/>	Mumps Y <input type="checkbox"/> N <input type="checkbox"/>
Urinary Infections Y <input type="checkbox"/> N <input type="checkbox"/>	Red Measles Y <input type="checkbox"/> N <input type="checkbox"/>	Other _____

Development & Behavior
Insert age at which child did:
Sat Alone _____ Toilet trained _____
Walked _____ Used Sentences _____
Development compared to other children? _____

Problems in school Y <input type="checkbox"/> N <input type="checkbox"/>
Learning problems Y <input type="checkbox"/> N <input type="checkbox"/>
Gets along with other children Y <input type="checkbox"/> N <input type="checkbox"/>
Behavior problems Y <input type="checkbox"/> N <input type="checkbox"/>
Bad Habits Y <input type="checkbox"/> N <input type="checkbox"/>
Bedwetting Y <input type="checkbox"/> N <input type="checkbox"/>
Nail biting Y <input type="checkbox"/> N <input type="checkbox"/>

Feeding & Nutrition	
Food Allergies _____	
Appetite usually good Y <input type="checkbox"/> N <input type="checkbox"/>	
Colic or feeding problems during the first 3 months Y <input type="checkbox"/> N <input type="checkbox"/>	
Breast fed? Y <input type="checkbox"/> N <input type="checkbox"/> Numbers of months _____	
Formula Y <input type="checkbox"/> N <input type="checkbox"/> Current brand _____	
Vitamins? Y <input type="checkbox"/> N <input type="checkbox"/> Brand _____ Fluoride Y <input type="checkbox"/> N <input type="checkbox"/>	
Special diet? Y <input type="checkbox"/> N <input type="checkbox"/>	

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