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?

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-

Past Medical History

Have you ever had any allergic reactions to the following:

Medicine Y☐ N☐ **Food** Y☐ N☐ **Animals** Y☐ N☐ **Insects bites** Y☐ N☐ If yes, list-

1.

2.

Medications taken on a regular basis? (excludes vitamins)

Immunizations up to date? Yes☐ No☐ Do you have a record with you? Yes☐ No☐

Hospitalizations - Yes☐ No☐ (when-where-why?) If yes, list-

1. 3.

2. 4.

Surgeries - Yes☐ No☐ (when-where-why?) If yes, list-

1. 3.

2. 4.

Serious injuries (when-where?)

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

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

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☐

Special diet? Y☐ N☐

Development & Behavior

Insert age at which child did:

Sat Alone Toilet trained

Walked Used Sentences

Development compared to other children?

Problems in school Y☐ N☐

Learning problems Y☐ N☐

Gets along with other children Y☐ N☐

Behavior problems Y☐ N☐

Bad Habits Y☐ N☐

Bedwetting Y☐ N☐

Nail biting Y☐ N☐