NEW PATIENT QUESTIONNAIRE
WHITTIER PEDIATRIC GROUP

TO BE FILLED OUT BY PARENT OR GUARDIAN

Mother's name:______________________ Age________
Occupation:______________________________________
Father's name:________________________ Age_______
Occupation:______________________________________

Patient's name:________________________________
Patient's Date of Birth:_________________________

If adults in the household work outside the home, what child care arrangements are made for this child? ______________________

A. PREGNANCY AND BIRTH: REVIEW OF SYSTEMS:

1. Mother's age at birth. ______________
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron? No Yes
4. Was the baby born on time? No Yes
5. What was the baby's birth weight ______________
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes
   What kind?_____________________________________

B. PAST MEDICAL HISTORY:

1. Where has your child gone for check-ups 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? No Yes
   Which ones?_____________________________________
5. Has your child had reactions to any immunizations? No Yes
   Which ones?_____________________________________
6. Any hospitalizations other than for birth? No Yes
   For what?_______________________________________
7. Any serious injuries? No Yes
   What kind? ______________________________________
8. Are any medications taken regularly? No Yes

C. FAMILY HISTORY:

1. Are the child's parent both in good health? No Yes
2. **Circle** any diseases that this child's parents, grandparents, brothers, sisters, aunts and uncles have had: anemia, asthma, allergies, diabetes, high nail biting, thumb sucking, bed wetting, problems with blood pressure, heart trouble, tuberculosis, mental illness, drug problems, toilet training, bad temper, hyperactivity, nightmares, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others.
3. List age, sex, and general health of brothers and sisters:____
4. Have any of children died? No Yes

D. FEEDING AND NUTRITION:

1. Is your child/s appetite usually good? No Yes
2. Is it good now? No Yes
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 5 months, is he/she (was he/she) breast fed or bottle fed?_______________________________

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problem? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throat? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problem.
    ____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? ______________________
2. At what age did he/she walk alone? ______________________
3. Did he/she say any words by the time he/she was 1 ½ years old? No Yes
4. How does this child compare to others his or her age? ____________________________
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? ___________________________
7. Has he/she get along with other children? No Yes
8. Does he/she get along with other children? No Yes
9. **Circle** if your child has had any of the following: speech problems, problems with discipline, other.

G. SAFETY/ENVIORMENT:

1. Do you live in a private house, apartment, mobile home, other **(CIRCLE)**
2. Do you know the hottest temperature of the water in your pipes? No Yes
3. Is there a working smoke alarm on each floor in the house? No Yes
4. Does your child always use a car seat/seat belt when riding in a car? No Yes
5. Are there any smokers in the household? No Yes
6. Are there any problems with the condition of your Home? (peeling paint, insects, rats or mice. No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes

H. DO YOU HAVE A RECORD OF IMMUNIZATION? No Yes

SIGNATURE:____________________________________
(PARENT OR GUARDIAN)

DATE:____

DOCTOR'S SIGNATURE:___________________________

DATE:____