Chula Vista (619) 482-1700
National City (619) 475-4575
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NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT

CHILD'S NAME _____

MOTHER'S NAME _____

DATE OF BIRTH _____

FATHER'S NAME _____

A. PREGNANCY AND BIRTH

1. MOTHER'S AGE AT BIRTH _____
2. MATERNAL ILLNESS DURING PREGNANCY? NO YES
3. ANY MEDS OTHER THAN VITAMINS AND IRON? NO YES
4. WAS THE BABY ON TIME (>37 WKS)? YES NO
5. WAS THE BABY BREECH? NO YES
6. WHAT WAS THE BIRTH WEIGHT? _____
7. DID THE BABY HAVE ANY TROUBLE WHILE IN THE HOSPITAL? (JAUNDICE, INFECTION, BREATHING PROBLEMS) NO YES
8. WHAT KIND?

_____

B. PAST MEDICAL HISTORY

1. WHERE HAS YOUR CHILD GONE FOR CHECK-UPS LAST?
2. DATE OF LAST CHECK-UP? _____
3. ALLERGIC REACTION TO MEDS, FOOD, INSECTS? NO YES

WHICH ONES?

_____

4. ANY SERIOUS REACTIONS TO IMMUNIZATIONS? NO YES

WHICH ONES?

_____

PATIENT INFORMATION FORM

5. ANY HOSPITALIZATIONS BESIDES BIRTH? NO YES

FOR WHAT?

_____

6. ANY SERIOUS INJURIES? NO YES

WHAT KINDS?

_____

7. MEDICATIONS TAKEN REGULARLY OR CURRENTLY? NO YES

WHICH ONES?

_____

C. FAMILY HISTORY

1. ARE THE CHILD'S PARENTS IN GOOD HEALTH? YES NO

2. CIRCLE ANY DISEASES THAT THIS CHILD'S PARENTS, GRANDPARENTS, SIBLINGS, AUNTS, UNCLES, COUSINS HAVE HAD:

ANEMIA, ASTHMA, ALLERGIES, ECZEMA, DIABETES, HIGH BLOOD PRESSURE, HEART TROUBLE, HIGH CHOLESTEROL, TUBERCULOSIS, MENTAL ILLNESS, DRUG PROBLEMS, INHERITED ILLNESS, CANCER, AIDS, LEARNING DISORDER, ATTENTION DEFICIT DISORDER OR HYPERACTIVITY, STRABISMUS, OTHERS.

3. LIST AGE, SEX, AND GENERAL HEALTH OF BROTHERS AND SISTERS

_____

4. HAVE ANY OF YOUR CHILDREN DIED? NO YES

D. FEEDING AND NUTRITION

1. WAS THERE SEVERE COLIC OR ANY UNUSUAL FEEDING PROBLEM DURING THE FIRST THREE MONTHS?

NO YES

2. IF BREASTFED, FOR HOW LONG? _____

3. DOES HE/SHE TAKE: VITAMINS OR FLUORIDE? YES NO

4. DOES YOUR CHILD USE HOMEOPATHIC OR HERBAL MEDICINES? NO YES

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E. REVIEW OF SYSTEMS HAS YOUR CHILD HAD:

1. FREQUENT EAR INFECTIONS? NO YES

2. EYE PROBLEMS, GLASSES? NO YES

3. FREQUENT COLDS OR SORE THROATS? NO YES

4. CHICKENPOX? NO YES

5. ASTHMA, PNEUMONIA, RECURRENT COUGH? NO YES

6. HEART MURMUR OR HEART PROBLEMS? NO YES

7. PROBLEMS WITH URINATION, URINE INFECTIONS? NO YES

8. FREQUENT DIARRHEA OR CONSTIPATION? NO YES

9. CONVULSIONS OR OTHER PROBLEMS WITH THE NERVOUS SYSTEM? NO YES

10. ECZEMA, HIVES OR OTHER SKIN CONDITIONS? NO YES

11. ANEMIA OR OTHER BLOOD PROBLEMS? NO YES

12. PLEASE LIST ANY OTHER MEDICAL PROBLEMS

13. LIST ANY SUBSPECIALISTS YOUR CHILD HAS SEEN

_____

F. DEVELOPMENT/BEHAVIOR

1. AGE HE/SHE SAT ALONE? _____

2. AGE HE/SHE WALKED ALONE? _____

3. WAS HE/SHE SAYING WORDS BY 18 MONTHS? YES NO

4. DOES HE/SHE HAVE TROUBLE SLEEPING? NO YES

5. WHAT GRADE IS HE/SHE IN? _____

6. HAS HE/SHE HAD ANY TROUBLE IN SCHOOL? NO YES

7. DOES HE/SHE GET ALONG WITH OTHER CHILDREN? YES NO

8. CIRCLE IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING: THUMB SUCKING, BED WETTING, PROBLEMS WITH TOILET TRAINING, HYPERACTIVITY, NIGHTMARES, SPEECH PROBLEMS, PROBLEMS WITH DISCIPLINE

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PATIENT INFORMATION FORM

G. SAFETY/ENVIRONMENT

1. ARE THE PARENTS OF THE CHILD: MARRIED, DIVORCED, SEPARATED, DECEASED

2. THE CHILD LIVES WITH: BOTH, ONE, JOINT CUSTODY., GUARDIAN, FOSTER, STEPMOTHER, STEPFATHER, OTHER

3. IS THE CHILD ADOPTED? NO YES

4. THE CHILD IS ALSO IN: DAY CARE, PRESCHOOL, WITH NANNY,WITH RELATIVES

5. ARE THERE ANY PETS AT HOME? NO YES

6. ARE THERE SMOKERS THE CHILD IS EXPOSED? NO YES

7. DO YOU HAVE A POOL SPA, POND? NO YES

8. DOES HE/SHE ALWAYS WEAR A HELMET WHEN BICYCLING OR SKATING? YES NO

9. DOES HE/SHE ALWAYS USE A CAR SEAT/BELT? YES NO

H. RECORDS

1. DO YOU HAVE A RECORD OF IMMUNIZATIONS? YES NO