Tatiana Bidikov M.D. Model City Pediatrics New Patient Questionnaire

Mother's Name _____ Age _____ Patient's Name _____

Occupation _____ Chart # _____

Father's Name _____ Age _____ Date _____

Occupation_____

If adults work outside the home what childcare arrangements are made for this child? _____

Pregnancy and Birth

1. Mother's age at Birth _____
2. Did mother have any illness during pregnancy? _____
3. Did she take any medications other than vitamins and iron? _____
4. Was the baby on time? _____
5. What was the birth weight? _____
6. Did the baby have any trouble starting to breath? _____
7. Did the baby have any trouble while in the hospital (jaundice, infections, other)? _____

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 medication, food, insect bites? _____
5. Has your child had a reaction to immunizations? _____
6. Any hospitalizations other than for birth? _____
7. Any serious injuries? _____ What kind? _____
8. Are any medications taken regularly? _____
   What ones? _____

Family History

1. Are the child's parents both in good health? _____
2. Circle the disease that this child's parents, grandparents, brothers, sisters, or aunt and uncles have: anemia, asthma, allergies, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others_____
3. List age, sex, and good health of sibilings_____

Feeding and Nutrition

1. Is your child's appetite usually good? _____
2. Is it good now? _____
3. Was there severe colic or any unusual feeding problems during the first 3 months? _____
4. Do any foods disagree with him/her? _____
5. For the first 6 months is/was the baby breast fed or bottle fed? _____
6. If still on formula, which one do you use? _____
7. Does/she take vitamins? _____

Review of systems

1. Has your child had frequent ear infections? _____
2. Any eye problems? _____
3. Has he/she had any problems with teeth? _____
4. Does he/she have frequent colds or sore throat? _____
5. Is there asthma, pneumonia, or recurrent cough? _____
6. Does he/she have a heart murmur or any heart problem? _____
7. Any problems with urination? _____
8. Any problems with diarrhea or constipation? _____
9. Has there been any convulsions or other problems with the nervous system? _____
10. Any eczema, hives, or other skin condition? _____
11. Has your child ever been anemic? _____
12. Please list any other medical problems. _____

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? _____
4. How does this child compare to others his or her age? _____
5. Does he/she have through sleeping? _____
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? _____
8. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others_____

Safety/ Environment

1. Do you live in a private house, apartment, mobile home?_____
2. Do you know the hottest temperature of the water in your pipes? _____
3. Is there a working smoke alarm on each floor in your house? _____
4. Does your child always use a car seat/seat belt when riding in a car? _____
5. Are there any smokers in the household? _____
6. Are there any problems with the condition of your home? (pipelines, paint, insects, rats or mice?)_____
7. Does your child always wear a helmet when riding his/her bicycle? _____

Whom may we thank for referring you to our practice?_____