(initials)

Cornerstone Pediatric & Adolescent Medicine

New Patient Questionnaire

Name ______________________ **DOB** ____________ **Chart #** ____________

Person Filling Out This Form? (circle): Mother Father Other: ____________

Mother's Name: ______________________ Age: ______
Father's Name: ______________________ Age: ______

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

Please circle one. If YES, please explain in the lines provided to the right.

A. PREGNANCY AND BIRTH:

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 & iron? No Yes
4. Alcohol? No Yes
5. Cigarette use? No Yes
6. Marijuana / Drugs? No Yes
7. History of herpes, HIV, or other genital infections? No Yes
8. What was your due date? ______
9. Vaginal or cesarean? ______
10. If cesarean Why? ______________________
11. What was the birth weight? ______
12. Did the baby have any trouble starting to breathe? No Yes
13. Did the baby have any trouble while in the hospital? No Yes
    (jaundice, infections, other?) No Yes

B. PAST MEDICAL HISTORY

1. Any serious past medical problems? No Yes
2. Any past surgery (including ear tubes)? No Yes
3. Date of last checkup: ______________________
4. Date of last dental checkup: ______________________
5. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
6. Has your child had reactions to any immunizations? No Yes
7. Any hospitalizations other than for birth? No Yes
8. Any serious injuries? No Yes
9. Take medications regularly? No Yes
10. Alternative medicine / Herbal remedies? No Yes

C. FAMILY HISTORY

1. Are the child's parents both in good health? No Yes
2. Please indicate if mother (M), father (F), siblings (S), grandparent (GF, GM, ect.) have had any of the following:

Arthritis	______	Allergy (type)	______
High cholesterol	______	______	______
High Blood pressure	______	Inherited/genetic	______
Stroke	______	Cystic fibrosis	______
Diabetes	______	Sickle cell	______
Kidney disease	______	Hemophilia	______
Alcoholism	______	Seizures	______
Drug abuse	______	Emotional problems	______
AIDS	______	Obesity	______
Hepatitis	______	Birth defect	______
Tuberculosis	______	Cancer	______

3. List age, sex and general health of brothers and sisters ______________________

4. Have any of your children died? No Yes

Signature ______________________ **Date** ____________

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Please circle one. If YES, please explain in the lines provided to the right.

First Name: ______________ Chart # __________

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 problems? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, did you breast or bottle feed?__________
   Which do you use now (note brand of formula):__________
6. Does he/she take vitamins? No Yes
7. Any herbal supplements? No Yes

E. REVIEW OF SYSTEMS

1. Has your child had any of the following?
   - Frequent ear infections? No Yes
   - Hearing problems? No Yes
   - Eye problems? No Yes
   - Problems with teeth? No Yes
   - Frequent colds or sore throats? No Yes
   - Asthma, pneumonia, or recurrent cough? No Yes
   - Heart murmur or any heart problems? No Yes
   - Problems with urination? No Yes
   - Diarrhea or constipation? No Yes
   - Convulsions or other central nervous system problems? No Yes
   - Eczema, hives or other skin conditions? No Yes
2. Please note any other medical problems:__________

F. DEVELOPMENT/BEHAVIOR

1. Age your child sat alone? ______mo.
2. At what age did he/she walk alone ______mo.
3. Did he/she say any words by 1 ½ years of age No Yes
4. How does this child compare to others his/her age?__________
5. Any trouble sleeping? No Yes
6. Grade in school? ______
7. Trouble getting along well with other children? No Yes
8. Circle if your child has any of the following:

nail biting	nightmares / sleep problems
thumb sucking	speech problems
bedwetting	discipline problems
problems with toilet training	bad temper
hyperactivity	other

EXPLAIN:__________

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, mobile home, other (circle one)
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 your house? No Yes
4. Does your child always us a car seat/seat belt when riding in a car? No Yes
5. Are any smokers in the house? No Yes
6. Are there any problems with the condition of your home? (peeling paint, insets, rats, ect.) No Yes
7. Does your child always wear a helmet when riding a a bicycle, scooter, skateboard, rollerblading or skating? No Yes
8. Are parents: (circle one)
   Married Divorced Separated Widowed
9. With whom and where does the child reside?

Signature ____________________ **Date** __________