New Patient Questionnaire

Date____

Patient's Name____________________________________

Date of Birth______________________________________

Or place label here:

Birth History:

Time of Birth________

Birth weight__________ Birth length________

How many weeks of pregnancy was the baby born at?
_________weeks

Was the delivery ☐Vaginal? ☐ Cesarean?
If cesarean, why? ________________________

Group B Strep (GBS) status of mother?
☐Negative ☐Positive ☐unknown
If positive, was mother treated with antibiotics?
☐Yes ☐No ☐unknown

Maternal blood type ______ ☐unknown
Infant blood type ______ ☐unknown

Did the child pass the newborn hearing screen?
☐Yes ☐No ☐unknown

Was Hepatitis B vaccine given prior to discharge?
☐Yes ☐No ☐unknown

Was Vitamin K given at birth?
☐Yes ☐No ☐unknown

Was initial feeding ☐Breast? ☐Bottle?

Did mother have any illnesses or problems with her pregnancy? ☐Yes ☐No
Explain_____________________________________

During Pregnancy, did mother
Smoke ☐Yes ☐No
Drink Alcohol ☐Yes ☐No
Use drugs or medications ☐Yes ☐No
What ____________________________
When ____________________________

How many children does mother have? _______
Names: ______________________________________

Did your baby have any problems right after birth?
☐Yes ☐No
Explain_____________________________

Did your baby go home with mother from the hospital?
☐Yes ☐No Explain______________________________

Past Medical History

Does your child have, or has your child ever had,

Hospitalizations	Yes	No	Explain____________________________
Surgery	Yes	No	Explain____________________________
Chickenpox	Yes	No	Explain____________________________
Frequent ear infections	Yes	No	Explain____________________________
Problems with ears or hearing	Yes	No	Explain____________________________
Nasal allergies	Yes	No	Explain____________________________
Problems with eyes or vision	Yes	No	Explain____________________________
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	Explain____________________________
Any heart problem or heart murmur	Yes	No	Explain____________________________
Anemia or bleeding problem	Yes	No	Explain____________________________
Recurrent urinary tract infections and problems	Yes	No	Explain____________________________
Kidney disease or urologic malformations	Yes	No	Explain____________________________
Thyroid or other endocrine problems	Yes	No	Explain____________________________
History of serious injuries/fractures/concussions	Yes	No	Explain____________________________

Medications prescribed or taken on a regular basis_______________________________________

Allergies to medicine or drugs	Yes	No	Explain____________________________
Allergies to food or environmental triggers	Yes	No	Explain____________________________

Are your child's immunizations up to date? Yes No Explain____________________________

Who was your child's last primary care provider? _____

Previous provider contact information: _______________________________________

Did you fill out a records release today? Yes No

Is the patient Adopted? ☐ Yes ☐ No ☐ Family history unknown

*Did/does anyone in the **patient's** family have any of the following conditions? (Check all that apply)*

	Mother	Father	Sister	Brother	Maternal Grand-mother	Maternal Grand-father	Paternal Grand-mother	Paternal Grand-father
Allergies								
Arthritis								
Asthma/Respiratory								
Back Problems								
Blood Diseases (sickle cell, bleeding tendency, clotting disorders etc.)								
Cancer								
COPD								
Diabetes								
Drug/Alcohol Abuse								
Emphysema								
Endocrine								
Genetic Disorders								
GI/Stomach Problems								
GU/Kidney Disease								
Heart Problems								
Hypertension (high blood pressure)								
Immunological diseases/disorders								
Lipids (high cholesterol)								
Migraine								
Neurological Disorders (seizures)								
Obesity								
Psychiatric Illness, Mental Health Disorders								
Scoliosis								
SIDS (sudden infant death syndrome)								
Stroke								
Tuberculosis								
Thyroid Disorder								
Other								
No Significant Family History								
STATUS								
Alive								
Deceased								
Unknown								