



### New Patient Health Questionnaire

Name: \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_  M  F

Form completed by/Relationship: \_\_\_\_\_

**Household** Please list all those living in the home with your child

Name	Relationship to child	DOB	Health Issues - list

Are there siblings not listed? If so, please list names, ages & where they live. \_\_\_\_\_

Child lives with - if not with both biological parents:  
 Mom  Dad  Joint custody  single custody  
 Adoptive Parents  Foster Family

If one or both parents are not living in the home, how often does the child see the parents) not in the home?  
\_\_\_\_\_

**Birth History**  Don't know birth history  
Birth weight \_\_\_\_\_ Was baby term? \_\_\_\_\_ Or \_\_\_\_\_ # Weeks

**Delivery:**  Vaginal  Cesarean- why \_\_\_\_\_

**Prenatal or neonatal complications?**  No  Yes - explain: \_\_\_\_\_  
\_\_\_\_\_

**Initial Feeding:**  Formula  Breastfed - how long \_\_\_\_\_  
Did baby go home with mother from hospital?  Yes  No -  
Explain: \_\_\_\_\_

**NICU stay:**  No  Yes - Explain: \_\_\_\_\_  
\_\_\_\_\_

**During pregnancy, did mother-**  
 Take Pre-natal vitamins  Prescription Medications: What & When \_\_\_\_\_  
 Use drugs: \_\_\_\_\_ What & When \_\_\_\_\_  Use tobacco  Drink alcohol

**General: DK = don't know**  
Do you consider your child to be in good health?  Yes  DK  No: Explain: \_\_\_\_\_

Does your child have any serious illness or medical conditions?  No  DK  Yes - explain: \_\_\_\_\_  
\_\_\_\_\_

**Surgery:**  None  DK  Yes-explain: \_\_\_\_\_  
\_\_\_\_\_

**Hospitalizations:**  None  DK  Yes - explain: \_\_\_\_\_  
\_\_\_\_\_

**Allergies to medications/drugs:**  None  DK  Yes - explain: \_\_\_\_\_  
\_\_\_\_\_

Do you feel your family has enough to eat?  Yes  DK  No-explain: \_\_\_\_\_

Does your child have or ever had:				Explain
Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	When: _____
Frequent ear infections	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with ears or hearing	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with eyes or vision	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Nasal Allergies	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Heart problems or Heart murmur	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Anemia or Bleeding disorder	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Received Blood transfusions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
HIV	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Cancer, Malignancy/ Bone Marrow Transplant	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Chemotherapy	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Organ Transplant	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Kidney disease or urologic malformations	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Bed-wetting after age 5	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Recurrent Urinary tract infections & problems	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Frequent Abdominal pain	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Constipation requiring doctor visits	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Metabolic/Genetic disorders	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Developmental delay or disability	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Sleep problems - Snoring	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Chronic or recurrent skin issues - eg: acne/eczema	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Frequent Headaches	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Convulsions or other neurologic problems	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Thyroid or Endocrine issues	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
History of serious injuries/fractures, concussions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Use of Alcohol, Drugs, Tobacco	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Dental Decay	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
History of family violence	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Sexually transmitted infections	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
For Girls:				
Has had first period	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with periods	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Any other significant problems?				_____

## Biological Family History

Any family members with the following?				Who	Comments
Childhood hearing loss	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Nasal Allergies	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Heart Disease before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
High Cholesterol- on medication	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Bleeding disorder	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Dental Decay	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Cancer - before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Liver disease	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Diabetes - before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Bed-wetting after age 10	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Obesity	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Epilepsy or convulsions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Alcohol abuse	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Mental Illness/depression	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Developmental disability	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Immune problems, HIV or AIDS	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Tobacco Use	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Additional Family history	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		

*If there are multiple children in a family- copy page three and only complete one time.*

This New Patient Health Questionnaire is consistent with American Academy of Pediatrics  
& Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents.