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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

Prenatal or neonatal complications? ☐ No ☐ Yes – explain:

_____

_____

NICU stay: ☐ No ☐ Yes – Explain: _____

_____

Delivery: ☐ Vaginal ☐ Cesarean- why_____

_____

Initial Feeding: ☐ Formula ☐ Breastfed – how long _____

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

Biological Family History

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