Western Wake Pediatrics

New Patient Questionnaire - **CHILD** 1 year old and older

PATIENT'S NAME **Date of Birth**

Parent/Guardian Name Circle: Mother Father Other

Parent/Guardian Name Circle: Mother Father Other

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

CHILD'S PAST MEDICAL HISTORY

1. Has child had any medical problems? No Yes
2. Were there any problems with pregnancy or delivery? No Yes
3. Has child had any past surgery (including ear tubes)? No Yes
4. Date of last medical check up
5. Date of last dental check up
6. Has child had allergic reactions to any medication, food or insect bites? No Yes
7. Has child stayed overnight in the hospital, other than at birth? No Yes
8. Has child had any serious injuries? No Yes
9. Does the child take medications, vitamins, or supplements regularly? No Yes
10. Does the child use alternative medicine/herbal remedies? No Yes
11. Has child ever had physical therapy, speech therapy, or occupational therapy? No Yes

FAMILY HISTORY

Please indicate if mother (M), father (F), siblings (S), maternal or paternal grandparent have had any of the following?

Arthritis	HIV/AIDS	Emotional problems
High cholesterol	Hepatitis	Obesity
High blood pressure	Tuberculosis	Birth defect
Stroke	Allergy (type)	Cancer
Diabetes	Cystic fibrosis	Tobacco Smoker
Kidney Disease	Sickle cell	Seizures
Drug use	Alcoholism	Other
Hemophilia, bleeding or clotting disorders		

Has any of your children died? No Yes

List name, age, and relationship (brother, sister, half-sister, step-brother, etc) of patient's siblings

REVIEW OF SYSTEMS

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
- Hyperactivity No Yes
- Speech problems No Yes
- Other (explain)

PATIENT'S NAME **Date of Birth**

SAFETY AND ENVIRONMENT

1. Is your water heater set to a max temp. of 120 degrees? No Yes
2. Is there a working smoke alarm on each floor in your home? No Yes
3. If there are guns in your home, are they kept locked with ammunition locked separately? No Yes
4. Does your child always use a seatbelt and/or carseat? No Yes
5. Does your child always wear a helmet when riding a bicycle, scooter, skateboard, etc? No Yes
6. Are there any smokers in the home? No Yes
7. Do you have concerns about the condition of your home? (peeling paint, insects, rats) No Yes
8. Do you need help finding stable housing? No Yes
9. Do you need help buying food for your family? No Yes
10. Are parents (circle one) Married Divorced Separated Widowed Together but not married
11 With whom and where does the child live?
12. Who has legal custody/medical decision making authority for the patient?

Signature **Date**