Western Wake Pediatrics

New Patient Questionnaire - **INFANT** under 1 year old

PATIENT'S NAME **Date of Birth**

Parent/Guardian Name Circle: Mother Father Other:

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

PREGNANCY AND BIRTH

1. Mother's age at birth
2. Did mother have an illness during pregnancy? No Yes
3. During pregnancy did mother use any medications other than vitamins? No Yes
   a. Alcohol? No Yes
   b. Cigarettes or vaping? No Yes
   c. Marijuana? No Yes
   d. Other drugs? No Yes
4. History of herpes, HIV, or other genital infections? No Yes
5. Was baby born on time? If early, how many weeks early? No Yes
6. Vaginal or cesarean?
   a. If cesarean, why?
7. What was the birth weight?
8. Did the baby have any trouble starting to breathe? No Yes
9. Did the baby have any trouble while in the hospital? (jaundice, infections, trouble starting to breathe?) No Yes

CHILD'S PAST MEDICAL HISTORY

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

PATIENT'S NAME **Date of Birth**

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	

Other: _____

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 carseat when riding in a car?	No	Yes	
5. Are there any smokers in the home?	No	Yes	
6. Do you have concerns about the condition of your home? (peeling paint, insects, rats, etc)	No	Yes	
7. Do you need help finding stable housing?	No	Yes	
8. Do you need help buying food for your family?	No	Yes	

8. Are parents (circle one): Married Divorced Separated Widowed Together but not married

9. With whom does the child live? _____

10. Who has legal custody/medical decision making authority for the patient _____

Signature _____ **Date** _____