Kids First Pediatric Clinic, LLC
1673 10th Street,WestLinn,OR97068
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NEW PATIENTQUESTIONNAIRE

Patient's Name_____DOB:_____Today's Date _____

Mother's Name_____Age____Father's Name_____Age ____

PREGNANCY AND BIRTH

Mother's at child's birth _____

What number pregnancy was this child? _____

Did mother have any illness during pregnancy? Y ☐ N ☐

Did she take any medications other than vitamins and iron? Y ☐ N ☐

If yes, what? _____

Was the baby on time? Y ☐ N ☐
If no, how early was your baby? _____

Were there any complications with the baby during delivery?_____

Was the delivery **vaginal** or by **C-section**?_____

	Y	N
Did the baby go home at the same time as mom?	☐	☐
Did the baby have any trouble while in the hospital?	☐	☐

(Jaundice, Infections, other?) _____

Did the baby go to the NICU? Y ☐ N ☐

If yes, please give a brief synopsis of the course:

If so, how long were they there? _____

If on ventilator, how long? _____

If on oxygen, how long? _____

Other info (infections, surgeries, interventions) while in NICU:

_____

_____

Birth Weight Birth Length

Are your child vaccinations up to date? Y ☐ N ☐

If not, why?_____

_____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y/N

Was there severe colic or any unusual feeding problems during the first 3 months? Y/N

Do any foods disagree with him/her? Y/N

If so, what? _____

For the first 6 months, is (s)he was breast-fed or bottle-fed?

If still on formula, which one? _____

Does (s)he take vitamins? Y/N

DEVELOPMENT/BEHAVIOR

How does child compare to others of same age?

_____

Does child haven any of the following (Y/N)?

- Thumb sucking
- Bed wetting
- Problems with toilet training
- Nail biting
- Bad temper
- Problems with discipline
- Speech problems
- Hyperactivity
- Nightmares
- Other

X _____ Initials

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Has your child had any of the following medical problems? Please circle one

- ☐ Serious injuries or accident
- ☐ Hospitalization
- ☐ Surgeries
- ☐ Chickenpox disease
- ☐ Hearing loss
- ☐ Anemia or bleeding problem
- ☐ Kidney problem
- ☐ Eczema
- ☐ Learning disorder
- ☐ Frequent ear infection
- ☐ Heart problem or murmur
- ☐ Blood transfusion
- ☐ Bladder of kidney infection
- ☐ Bedwetting (after 6 years of age)
- ☐ Use of alcohol or drugs
- ☐ Constipation requiring Dr. Visits
- ☐ Asthma/ wheezing/ pneumonia
- ☐ Allergies-seasonal, animals, indoor, foods
- ☐ Allergic reactions- medications, vaccinations
- ☐ Frequent headaches, convulsions of other neurological problems
- ☐ Diabetes/ blood sugar problems
- ☐ Thyroid or other endocrine problems
- ☐ Other significant problems

PAST MEDICAL HISTORY

- Where has your child gone for check-ups until now?

  _____

- Date of last Check-up

  _____

- Date of last dental check-up

  _____

- Are any medications taken regularly? Y ☐ N ☐
- Please list names, dosages and frequency taken?
- _____

  _____

  _____

- If female, have periods started?

  _____

- When? _____

FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins or grandparents)

- ☐ Spina Bifida
- ☐ Bone disorder
- ☐ Cleft lip/palate
- ☐ Hearing loss/deafness
- ☐ Heart disease/defect
- ☐ Neurofibromatosis
- ☐ Mental retardation
- ☐ Neurological disorder
- ☐ Mental Illness
- ☐ Tuberculosis
- ☐ Hay fever/allergies
- ☐ Sickle Cell Anemia
- ☐ Muscle disorder
- ☐ Skin disease
- ☐ High blood pressure
- ☐ Urinary tract abnormality
- ☐ vision/eye problems
- ☐ cerebral Palsy
- ☐ ADD/learning disorder
- ☐ Convulsions
- ☐ Infertility
- ☐ Limb defects
- ☐ Down Syndrome
- ☐ Cystic fibrosis
- ☐ Short stature (<5ft)
- ☐ Diabetes
- ☐ Drug/alcohol problems
- ☐ Bleeding disorder
- ☐ Kidney disease
- ☐ Genital abnormality
- ☐ Asthma
- ☐ AIDS (HIV)
- ☐ High cholesterol/triglycerides
- ☐ Chromosome abnormality
- ☐ Brain anomalies (includes Hydrocephaly)
- ☐ Anemia (includes Thalassemia)
- ☐ Patient's mother was exposed to DES
- ☐ Other birth defect/malformations/problems?

Please list:_____

_____

List age, sex, and health problems of brothers and sisters (are they living)?

_____

_____