

**CAPITALCARE PEDIATRICS CLIFTON PARK
NEW PATIENT QUESTIONNAIRE
TO BE FILLED OUT BY PARENT OR GUARDIAN**

Name:	Date of birth:	Known allergies:
Mother's name:	Age:	Occupation:
Father's name:	Age:	Occupation:

If adults in the household work outside the home, what child care arrangements are made for your child?

PREGNANCY AND BIRTH

Mother's age at birth: _____

Did the mother have any illness during pregnancy? N Y

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

Was the baby on time? Y N

What was the birth weight? _____

Did the baby have any trouble starting to breathe? N Y

Did the baby have any trouble while in the hospital? N Y

What kind? _____

PAST MEDICAL HISTORY

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

Date of last check-up: _____

Has your child had allergic reactions to any medications, foods, insect bites? N Y

Which ones? _____

Has your child had reactions to any immunizations? N Y

Which ones? _____

Any hospitalizations other than for birth? N Y

For what? _____

Any surgery? N Y

For what? _____

Any serious injuries? N Y

What kind? _____

Are any medications taken regularly? N Y

Which ones? _____

FAMILY HISTORY

Are the child's parents both in good health? Y N

Check any diseases that the child's parents, grandparents, siblings, or aunts and uncles have had:

anemia	heart trouble	inherited illness
asthma	tuberculosis	venereal disease
allergies	cancer	drug problems
diabetes	hypertension	alcohol problems
AIDS	mental illness	other:

List age, sex, and general health of siblings:

FEEDING AND NUTRITION

How did you feed your child during the first year of life (breast fed or bottle fed, how long)? _____

If bottle fed, which formula? _____

Was there severe colic or any unusual feeding problem during the first three months? N Y

Is your child's appetite usually good? Y N

Is it good now? Y N

Do any foods disagree with him/her? N Y

Which ones? _____

Does he/she take vitamins and/or fluoride? Y N

REVIEWED BY: _____

REVIEW OF SYSTEMS

Has your child had frequent ear infections? N Y

Any eye/vision problems? N Y

Has he/she had problems with teeth? N Y

Does he/she have frequent colds or sore throats? N Y

Is there asthma, pneumonia, or recurrent cough? N Y

Does he/she have a heart murmur or any heart problems? N Y

Any problems with diarrhea or constipation? N Y

Any problems with urination? N Y

Have there been any convulsions or other problems with the nervous system? N Y

Any eczema, hives, or other skin problems? N Y

Has your child ever been anemic? N Y

Please list any other medical problems:

DEVELOPMENT/BEHAVIOR

At what age did your child sit alone? _____

At what age did he/she walk alone? _____

Did he/she say any words by the age of 1½ yrs? Y N

Does he/she have any trouble hearing? N Y

How would you compare your child's development to others his/her age? _____

Does he/she get along with other children? Y N

Where does he/she go to school? _____

What grade is he/she in? _____

Has he/she had any trouble in school? N Y

What kind? _____

Check if your child has had any of the following:

<input type="checkbox"/>	nail biting	<input type="checkbox"/>	thumb sucking
<input type="checkbox"/>	bed wetting	<input type="checkbox"/>	problems toilet training
<input type="checkbox"/>	bad temper	<input type="checkbox"/>	hyperactivity
<input type="checkbox"/>	nightmares	<input type="checkbox"/>	speech problems
<input type="checkbox"/>	discipline problems	<input type="checkbox"/>	peer interaction problems

DO YOU HAVE A RECORD OF YOUR CHILD'S IMMUNIZATIONS?

Y N

SAFETY/ENVIRONMENT

Is there a working smoke alarm on each floor in the house? Y N

Does your child always use a car seat/seat belt when riding in the car? Y N

Are there any smokers in the household? N Y

Are there any problems with the condition of your home (peeling paint, insects, etc)? N Y

Does your child always wear a helmet when riding his/her bicycle? Y N

Is there a gun in the home? N Y

DO YOU HAVE ANY OTHER CONCERNS ABOUT YOUR CHILD?

DATE: _____