LOUISVILLE PEDIATRIC SPECIALISTS, PC.

New Patient Questionnaire
(To be filled out by parent or legal guardian)

Patient's Name:	AGE:	DOB:
Address:		
Parent/Guardian:	AGE:	DOB:
Address:		
Occupation:		
Parent/Guardian:	AGE:	DOB:
Address:		
Occupation		

(Please check appropriate answer)

A. PREGNANCY & BIRTH	**YES**	**NO**	**COMMENTS**
Mother's age at birth if child			
Did mother have any illness during pregnancy?			
Did she take any medications other than vitamins or iron?			
Was the baby born on time?			
What was the birth weight?			
Did the baby have trouble starting to breathe?			
Did the baby have any trouble in the hospital? (Jaundice, infections, other?)			

B. PAST MEDICAL HISTORY	**YES**	**NO**	**COMMENTS**
Where has your child gone for checkups until now?			
Date of last checkup?			
Date of last dental checkup?			
Has your child had allergic reactions to any medications, food, insect bites? (If so, which ones?)			
Has your child had any reactions to immunizations? (If so, which ones?)			
Any hospitalizations other than that for birth?			
Any serious injuries?			
Any medications taken regularly? (If so, which ones?)			
Any operations?			

C. FAMILY HISTORY	**YES**	**NO**	**COMMENTS**
Are both children's parents in good health?			

Circle any disease that this child's parent, grandparents, siblings, aunts and uncles may have had:

Anemia Asthma Allergies Diabetes High Blood Pressure Heart Trouble Tuberculosis Mental Illness Drug Problems

Alcohol Problems Inherited Illness Venereal Disease Cancer AIDS Other:_______________

List age, sex, general health of brothers/sisters:

AGE	SEX	HEALTH
1.		
2.		
3.		
4.		

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D. FEEDING AND NUTRITION		**YES**	**NO**	**COMMENTS**
Is your child's appetite usually good?				
Is it now?				
Were there severe colic or any unusual feeding problems during the first 3 months?				
Do any foods disagree with him/her?				
For the first 6 mos. Is he/she breast or bottle fed?				
If still on formula, which one do you use?				
Does he/she take vitamins?				
E. REVIEW OF SYSTEMS		**YES**	**NO**	**COMMENTS**
Has your child had frequent ear infections?				
Any eye problems?				
Has he/she had any problems with teeth?				
Does he/she have frequent colds or sore throat?				
Is there asthma, pneumonia or recurrent cough?				
Does he/she have a heart murmur or any heart problems?				
Any type of kidney or bladder problems?				
Any problems with diarrhea or constipation?				
Have there been any convulsions or other problems with the nervous system?				
Any eczema, hives or other skin conditions?				
Has your child ever been anemic?				
Has any family member or your child been diagnosed with diabetes?				
Exposed to TB?				
Any type of orthopedic (bone) disorders?				
Please list any other medical problems:______________________________				
F. DEVELOPMENT/BEHAVIOR		**YES**	**NO**	**COMMENTS**
At what age did the child sit alone?				
At what age did he/she walk alone?				
Did he/she say any words by the time he/she was 1 ½ yrs. Old?				
How does this child compare to others his or her age? (CIRCLE ONE)				
Appropriate	**Inappropriate**			
Does he/she have trouble sleeping?				
What grade is he/she in?				
Has he/she had any trouble in school?				
Does he/she get along with other children?				
G. SAFETY/ENVIRONMENT		**YES**	**NO**	**COMMENTS**
Do you live in a (Please circle one)				
Home **Apartment**	**mobile home** **other**			
Do you know the hottest temperature of the water in your pipes?				
Is there a working smoke alarm on each floor of the house?				
Does your child always use a car seat/seat belt when riding in the car?				

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Are there any smokers in the household?				
Are there any problems with the condition of your home? (Insects, rodents, paint, etc.)				
Does your child always wear a helmet when riding his/her bike?				
H. IMMUNIZATIONS		**YES**	**NO**	**COMMENTS**
Do you have a record of immunizations?				