Grace Point Pediatrics

New Patient Questionnaire

*Patient's Name*_____ *Date of Birth*_____

HOUSEHOLD- Please list all those living in the child's home

Name	*Relationship to Child*	*Birth Date*	*Health Problems*

Are there siblings not listed? If so, please list their name and age and where they live. _____

_____

If mother & father are not living together, or if child does not live with parents, what is the child custody status. _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Mother's Occupation _____ *Mother's Employer* _____

Father's Occupation _____ *Father's Employer* _____

Does anyone in the house use tobacco? Yes □ No□ *Are there any pets in the home? Yes □ No□*

Activity Level? Sedentary Active Competitive Sports

Amt of TV/Video Games daily? _____*min/day*

Uses seatbelts Car seat Booster Seat

DEVELOPMENT

Are you concerned about your child's physical development? Yes □ *No□ Explain* _____

*Are you concerned about your child's emotional development? Yes □ No □ Explain*_____

*Are you concerned about your child's attention span? Yes □ No □ Explain*_____

Is your child in school? Yes□ No □

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special resource classes? _____

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Birth History

Any problems during the pregnancy? Yes □ *No*□ _____

Was mom on any medications? Yes □ *No*□ *If yes* _____

Birth Hospital? _____ *Birth Weight* _____ *lbs* _____*oz*

Was your child born: On Time *Early (weeks _____)* *Late (weeks _____)*

How was your baby born? Vaginally Delivery C-Section Vacuum Forceps

Any Problems with baby at birth? Yes □ *No*□ *If Yes* _____

Did child/children go home with mom from the hospital? Yes □ *No*□ _____

Past Medical History

*When was your child's Last well- check?*_____

Previous Doctor? _____ *Dentist?* _____

Does your child take any medications? Yes □ *No*□ _____

Any Medication Allergies? *No* □ *Yes*□ _____

Prior Hospitalization? *No* □ *Yes*□ _____

Is your son circumcised? *No* □ *Yes*□ _____

Other Prior Surgeries? *No* □ *Yes*□ _____

Has your child had a history of:

Please circle around which one:

ADHD/ADD *Anemia* *Asthma* *Wheezing* *Bedwetting*

Cerebral Palsy *Constipation* *Diabetes requiring insulin/Type 1 DM*

Developmental Delay *Ear infections* *Eczema* *Food Allergies*

Headache *Hearing Loss* *Heart Murmur* *Broken Bones*

Chicken Pox *Insulin Resistance/ Type II DM* *Obesity* *Pneumonia*

Seasonal Allergies *Seizures* *Sports Injury* *Urinary Tract Infection*

Urticaria/ Hives *Vaccine Reaction* *Vision Problems* *Vitamin D deficiency*

*Other*_____

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Family History

Considering the child's parents, grandparents, aunts, uncles, and siblings, is there a family history of:

Asthma? *Whom:* _____

Alcohol or Drug Abuse? *Whom:* _____

Anemia? *Whom:* _____

Bleeding Disorder? *Whom:* _____

Cancer? *Whom:* _____

Skin Cancer? *Whom:* _____

Breast Cancer? *Whom:* _____

Childhood or Sudden Infant Death? Whom: _____

Deafness? *Whom:* _____

Developmental Delay? *Whom:* _____

Diabetes? *Whom:* _____

Hearing problems? *Whom:* _____

Heart disease (before 50 years old)? Whom: _____

High Blood Pressure (before 50 years old)? Whom: _____

High Cholesterol? *Whom:* _____

Intellectual Disability? *Whom:* _____

Kidney Disease? *Whom:* _____

Liver Disease? *Whom:* _____

Mental Illness/ Depression? *Whom:* _____

Nasal Allergies? *Whom:* _____

Retinoblastoma? *Whom:* _____

Stroke/ Blood Clots? *Whom:* _____

Tuberculosis? *Whom:* _____

Vision Problems? *Whom:* _____