FOSTER CITY PEDIATRIC MEDICAL GROUP, INC.

NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT

Mother's name _____ Age _____
Occupation _____
Father's name _____ Age _____
Occupation _____
Who lives with child in the home? _____
If adults in the household work outside the home, what child care arrangements are made for this child? _____

CHILD'S NAME _____

DOB: _____

DATE: _____

A. PREGNANCY AND BIRTH:

1. Mother's age at child's birth? _____
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron? No Yes
4. Was the baby on time? Yes No
5. What was the birthweight? _____
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes
   What kind? _____

B. PAST MEDICAL HISTORY:

1. Where has your child gone for checkups until now? _____
2. Date of last check-up: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
   Which ones? _____
5. Has your child had reactions to any immunizations? No Yes
   Which ones? _____
6. Any hospitalizations other than for birth? No Yes
   For what? _____
7. Any serious injuries? No Yes
   What kind? _____
8. Are any medications taken regularly? No Yes
   Which ones? _____

C. FAMILY HISTORY:

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters or aunts and uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, migraine, others
3. List age, sex, and general health of brothers and sisters _____
4. Have any of your children died? No Yes

D. FEEDING AND NUTRITION:

1. Is your child's appetite usually good? Yes No
2. Is it good now? Yes No
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? _____
6. If still on formula, which one do you use? _____
7. Does he/she take vitamins? Yes No

E. REVIEW OF SYSTEMS:

1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throats? No Yes
5. Is there asthma, pneumonia, or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Is child seeing any other doctor or therapist? No Yes
13. Please list any other medical problems: _____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? _____
2. At what age did he/she walk alone? _____
3. Did he/she say any words by the time he/she was $1\frac{1}{2}$ years old? Yes No
4. How does this child compare to others his or her age? _____
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? _____
7. Has he/she had any trouble in school? No Yes
8. Does he/she get along with other children? Yes No
9. Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, others

G. SAFETY/ENVIRONMENT:

1. Is there a working smoke alarm on each floor in the house? Yes No
2. Does your child always use a car seat/seat belt when riding in a car? Yes No
3. Are there any smokers in the household? No Yes
4. Does your child always wear a helmet when riding his/her bicycle? Yes No

H. DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No

I. IF YOU HAVE SPECIFIC QUESTIONS OR CONCERNS FOR THE DOCTOR PLEASE WRITE THEM DOWN ON THE BACK OF THIS SHEET.