coast pediatrics

NEW PATIENT QUESTIONNAIRE

Child's Name_____
Parent #1 Name_____

Date of Birth_____
Parent #2 Name_____

A. Prenatal History

1. Maternal illness during pregnancy? **No Yes**
   What type?_____
3. Was the baby on time (>37 wks)? **Yes No**
4. Was the baby breech? **No Yes**
5. What was the birth weight? _____
6. Did the baby have any trouble in the hospital? (jaundice, infection, breathing problem) **No Yes**
7. What type of problems?_____
   _____
8. Is your child adopted? **No Yes**

B. Past Medical History (approximate dates OK)

1. Where has your child gone for check-ups last?____
   _____
2. Date of last check-up? _____
4. Any hospitalizations, surgeries, injuries? **No Yes**
   Dates & type_____
   _____
   _____
   _____
   _____
8. Allergic reactions to any medications? **No Yes**
   List:_____
9. Allergic reactions to foods, insects? **No Yes**
   List:_____

C. Review of Systems - HAS CHILD HAD…

Circle choices that are underlined if they apply

1. *Severe colic* or *unusual feeding problems* during the first 3 months of life? **No Yes**
2. If breastfed, how long? _____
3. Frequent *ear* or *sinus* infections? **No Yes**
4. *Eye problems*, *glasses*? **No Yes**
4. *Frequent colds* or *sore throats*? **No Yes**
5. Chickenpox? **No Yes**
6. *Asthma*, *pneumonia*, *recurrent cough*? **No Yes**
7. *Eczema*, *hives* or *other skin* problems? **No Yes**
8. *Heart murmur* or *heart problems*? **No Yes**
9. Problems with urinary tract infections? **No Yes**
10. Frequent *diarrhea* or *constipation*? **No Yes**
11. Convulsions? **No Yes**
12. *Developmental* or *school* problems? **No Yes**
13. Trouble getting along with friends? **No Yes**
14. *Anemia* or *other blood* problems? **No Yes**
16. Any other chronic major problems or diagnosis?
    _____
    _____
    _____
17. List any subspecialists your child has seen_____
    _____
    _____
18. **DO YOU HAVE A RECORD OF IMMUNIZATIONS? Yes No**

D. Family History

1. Are the parents in good health? **Yes No**
2. Circle any diseases that this child's parents, grandparents, siblings, aunts, uncles, cousins have: *asthma, hay fever, eczema, heart disease, high blood pressure, high cholesterol, diabetes, cancer, melanoma, congenital hip dysplasia, urinary reflux, kidney disease, sudden death, SIDS, mental illness, migraines, bedwetting, genetic disease, strabismus, attention deficit disorder, other learning disorders, tuberculosis, AIDS, cystic fibrosis, other birth defects*
3. Any other pertinent family history_____
   _____

E. Social History

1. Are the parents of the child: *married, divorced, separated, mother deceased, father deceased*
2. The child lives with: *both parents, mother, father, joint custody, stepmother, stepfather, guardian, foster parent, other*_____
3. The child is also in: *daycare, preschool, with nanny, with relatives, school*
4. List age, sex, and general health of brothers and sisters?_____
   _____
   _____

Email address: _____
May we sign you up for our email newsletter? **Yes No**
(We will not share with anyone else)

Use other side for additional comments…

For Office Use: Input into EMR, date_____, by_____ Immunization record into EMR: _____