North Texas Health Care Associates-Pediatrics

New Patient Questionnaire

Name_____Birthdate_____

Mother's Name_____Age____Occupation_____

Father's Name_____Age____Occupation_____

Birth History:

Gestation (was the baby on time?)_____Birthweight_____

Complications while at hospital (jaundice, infection, other) _____

Past Medical History:

Allergic reactions to medications/foods/insect bites?_____

Reactions to immunizations? Which ones? _____

Hospitalizations other than birth?_____

Any serious injuries?_____

Any surgeries? _____

Any medications taken regularly? _____

Has the child been treated for or diagnosed with any of the following:

Allergies……...Yes or No
Asthma……Yes or No
Frequent ear infections……Yes or No
Eye problems……...Yes or No
Hearing problems……Yes or No
Frequent colds, pneumonia, cough……Yes or No
Heart problems or murmur……..Yes or No
Problems with urination……..Yes or No
Seizers/convulsions……Yes or No
Skin conditions……Yes or No
Other:_____

Family History:

Circle any diseases that the child's parents, grandparents, brothers, sisters, aunts and uncles have had. If yes, please list which relation:

Anemia		High Blood Pressure	
Asthma		High Cholesterol	
Allergies		Mental Illness	
Cystic Fibrosis		Seizures	
Cancer		Sickle Cell	
Diabetes		Thyroid Problem	
Eczema		Tuberculosis	
Heart Problems		Other	

Have any of your children died? ……Yes or No