

A Bright Future Pediatrics

2100 Hedgcoxe Road Suite 190 Plano, TX 75025 (972) 208-8668 Fax (972) 208-3186

NEW PATIENT QUESTIONNAIRE

Patient's Name: _____ DOB: _____ Today's Date: _____

Mother's Name: _____ Age: ____ Father's Name: _____ Age: ____

PREGNANCY AND BIRTH

Mother's age at child's birth: _____

What number pregnancy was this child? _____

Did mother have any illness during pregnancy?

If yes, list illness: _____

Did mother take any medications other than vitamins and iron?

If yes, list medications: _____

Was the baby on time?

If no, how early was your baby? _____

Were there any complications with the baby during delivery?

Was the delivery vaginal or by C-section?

Did the baby go home at the same time as mom?

Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?)

If yes, list issues: _____

Did the baby go to the NICU?

If yes, please give a brief synopsis of the course:

If so, how long were they admitted? _____

If on ventilator, how long? _____

If on oxygen, how long? _____

Other info (infections, surgeries, interventions) while in NICU:

Birth Weight _____ Birth Length _____

Are your child's vaccinations up to date?

If not, why?

FEEDING AND NUTRITION

Is your child's appetite usually good?

Was there severe colic or any unusual feeding problems during the first 3 months?

Do any foods disagree with him/her?

If so, what? _____

For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? _____

If still on formula, which one? _____

Does he/she take vitamins?

DEVELOPMENT / BEHAVIOR

At what age did child sit alone? _____

At what age did child walk alone? _____

Did child say any words by the time he/she was 1 ½ years old?

How does child compare to others of the same age?

Does child have any trouble sleeping?

What grade is the child in? _____

Family Name or Initials: _____

New Patient Questionnaire 04.23.18 AY

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DEVELOPMENT / BEHAVIOR (CONTINUED)

Has child had any trouble in school?

Does child get along with other children?

Does child have any of the following?

Thumb sucking

Nail biting

Bed wetting

Bad temper

Problems with toilet training

Hyperactivity

Problems with discipline

Nightmares

Speech problems

Other

List: _____

PAST MEDICAL HISTORY

Where has you child gone for check-ups until now?

Date of last check-up? _____

Date of last dental check-up? _____

Are any medications taken regularly?

Please list names, dosages, and frequency taken:

If female, have periods started?

When? _____

List any problems or concerns regarding periods: _____

SAFETY / ENVIRONMENT

Do you live in a:

Private home

Apartment

Mobile home

Other: _____

Day care? _____ Sitter? _____

Child lives with...?

Mother

Father

Both Parents

Other relatives: _____

SAFETY / ENVIRONMENT (CONTINUED)

Do you know the hottest temperature of the water in your pipes?

Is there a working smoke alarm on each floor in the house?

Does your child always use a car seat/seat belt when riding in the car?

Are there any smokers in the household?

Are there any problems with the condition of your home? (peeling paint, insects, rats, or mice)

Are there any guns in the house?

Are there any pets in the house?

Has your child had any of the following medical problems?
(Please circle all that apply)

Serious injuries or accidents

Surgeries

Hospitalizations

Chicken pox disease

Frequent ear infections

Hearing loss

Heart problem or murmur

Anemia or bleeding problem

Diabetes / blood sugar problems

Frequent abdominal pain

Blood transfusion

Kidney problem

Bladder or kidney infection

Eczema

Bedwetting (after 6 years of age)

Learning disorder

Use of alcohol or drugs

Frequent headaches

Constipation requiring Dr Visits

Surgery

Allergies-seasonal, animals, indoor, foods

Allergic reactions-medications, vaccinations

Convulsions or other neurological problems

Thyroid or other endocrine problems

Other significant problem: _____

Family Name or Initials: _____

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FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins, or grandparents)

Spina Bifida	Vision / eye problems
Bone disorder	Cerebral Palsy
Cleft lip / palate	ADD / learning disorder
Hearing loss	Convulsions
Heart disease / defect	Infertility
Neurofibromatosis	Limb defects
Mental retardation	Down Syndrome
Neurological disorder	Cystic fibrosis
Mental illness	Short stature (<5ft)
Tuberculosis	Diabetes
Hay fever / allergies	Drug / alcohol problems
Sickle Cell Anemia	Bleeding disorder
Muscle disorder	Kidney disease
Skin disease	Genital abnormality
High blood pressure	Asthma
Urinary tract abnormality	AIDS (HIV)
High cholesterol / triglycerides	Chromosome abnormality
Brain anomalies (includes Hydrocephaly)	Anemia (includes Thalassernia)

Patient's mother was exposed to DES

Other birth defect/malformations/problems?

Please list: _____

Siblings: List health problems, gender, date of birth, date of death (if applicable): _____

Family Name or Initials: _____