A Bright Future Pediatrics

7211 Preston Road Suite T 3700 Plano, Texas 75024 (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? Y N
If yes, list illness: _____

Did mother take any medications other than vitamins and iron?
If yes, list medications: _____

Was the baby on time? Y N
If no, how early was your baby?
_____

Were there any complications with the baby during delivery? Y N
_____

Was the delivery vaginal or by C-section? (Circle one)
Y N

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

Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?) Y N
If yes, list issues: _____
_____

Did the baby go to the NICU? Y N

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? Y N

If not, why?
_____
_____
_____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y N

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

Do any foods disagree with him/her? Y N
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? Y N

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?
Y N

How does child compare to others of the same age?
_____

Does child have any trouble sleeping? Y N

What grade is the child in? _____

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DEVELOPMENT / BEHAVIOR (CONTINUED)

Has child had any trouble in school? Y N

Does child get along with other children? Y N

Does child have any of the following? (Circle all that apply)

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? Y N

Please list names, dosages, and frequency taken:

_____
_____
_____
_____
_____

If female, have periods started? Y N
When? _____
List any problems or concerns regarding periods: _____
_____
_____

SAFETY / ENVIRONMENT

Do you live in a: (Please circle)

Private home Apartment

Mobile home Other: _____

Day care?_____Sitter? _____

Child lives with…? (Circle one)

Mother Father Both Parents

Other relatives: _____

SAFETY / ENVIRONMENT (CONTINUED)

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

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

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

Are there any smokers in the household? Y N

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

Are there any guns in the house? Y N
Are there any pets in the house? Y N

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: _____

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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): _____
_____
_____
_____