Washington Pediatric Associates, PC
NEW PATIENT QUESTIONNAIRE

Please fill out this questionnaire concerning your child's information. All information will be kept confidential in your child's medical records and will not be released without your permission.

Child's Name: _____
Date of Birth: _____
Mother's Name: _____
Date of Birth: _____ Occupation: _____
Father's Name: _____
Date of Birth: _____ Occupation: _____
Parents are: Married Divorced Separated Single
Siblings:
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Name: _____ Date of Birth: _____
Who lives at home with the patient? _____
_____

BIRTH HISTORY

Any problems during the pregnancy? YES NO
If YES, please describe: _____
Was mom on any medications during the pregnancy? YES NO
If YES, please describe: _____
Cigarettes/alcohol/drugs used during the pregnancy? YES NO
If YES, please describe: _____
Was your baby born?: On Time Late Early/Premature
Was your baby delivered?: Vaginal C-section Forceps Vacuum
Baby's birthweight? _____
Any complications with the baby? YES NO
If YES, please describe: _____

MEDICAL ISSUES

Where has your child gone for check-ups until now?
_____
Date of last check-up: _____
Has your child ever had any of the following:
Allergic reaction to food? NO YES
If YES, describe: _____
Allergic reaction to medicine? NO YES
If YES, describe: _____
Hospitalizations? NO YES
If YES, describe: _____
Surgery? NO YES
If YES, describe: _____
Medications? NO YES
If YES, describe: _____
Dental visit? NO YES
If YES, date of last visit: _____

Circle any of the following illnesses your child has had:
pneumonia asthma/wheezing febrile seizures other seizures
broken bones vaccine reaction urinary tract infection
tonsils/adenoids removed ear tubes hernia repaired
ear infections headaches vision problems heart murmur
bedwetting constipation eczema anemia sports injuries
allergies appetite/feeding concerns chicken pox (year: ____)

FAMILY HISTORY

Circle any of the following diseases that this child's parents, grandparents, aunts, uncles, brothers, or sisters have had:
Asthma Diabetes Allergies Eczema Seizures Sickle cell
Cancer (Type: _____) High blood pressure Heart disease
High cholesterol Sudden death Bleeding disorders
Blood clots Tuberculosis Mental illness Mental retardation
Inherited or genetic disorders Depression Alcoholism
Other: _____

SOCIAL/SAFETY HISTORY

Is there old peeling paint inside/outside the home? NO YES
Is there a working smoke alarm on each floor? NO YES
Are there any guns in your house? NO YES
If yes, are all firearms securely locked up? YES NO
Do you know the hottest water temperature in your pipes? YES NO
Is your child always buckled into a securely fastened carseat/seatbelt while riding in the car? YES NO
Do all other family members buckle up? YES NO
Does your child wear a helmet when bike riding, roller blading, or skateboarding? YES NO
Are there any smokers in the household or childcare setting? NO YES
Please circle any stresses in your household or environment:
Job difficulties Money worries Separation/divorce
Domestic violence Mental illness Drug/alcohol abuse
Incarceration Other: _____

DEVELOPMENT/SCHOOL CONCERNS

Has your child ever had any concerns regarding?:
(please circle your response)
Slow development (sitting, walking, talking) NO YES
Speech (late talker, hard to understand) NO YES
School difficulties (learning, attention) NO YES
Other concerns: _____
_____

THANK YOU FOR YOUR TIME AND COOPERATION.