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New Patient Health Questionnaire

Today's date:_____

Patient name:	DOB:	
Name of person completing:		
Relationship to patient:		
Birth History		
Birth weight	Birth Length	
Was the baby born at term?	Yes	No, _____ weeks
Delivery method	Vaginal	Cesarean
Were there any pregnancy or neonatal complications?	No	Yes
Did the baby go home with mother from the hospital?	Yes	No
Was initial feeding	Breastmilk	Formula
	How long breastfed?	
Is your child adopted?	No	Yes

General Medical History		
Do you consider your child to be in good health?	Yes	No
Any serious or chronic medical conditions?	No	Yes
Explain:		
Has your child ever had surgery?	No	Yes
Date(s) and type:		
Has your child ever been hospitalized?	No	Yes
Date(s) and reason:		
Are your child's immunizations up to date?	Yes	No
Does your child take any medications / vitamins?	No	Yes
List medications:		
Does your child have any allergies to medications?	No	Yes

List medication allergies:		
Does your child have any allergies to food?	No	Yes
List food allergies:		

Family Medical History (Have any family members had any of the following?)			
	No	Yes	Relationship to patient
Asthma / Lung Disease			
Allergies - environmental, food, medication			
Eczema			
Thyroid Problems			
Diabetes			
Heart Disease before age 55			
High Blood Pressure			
Kidney Disease			
Blood Disorders			
Hereditary Cancers			
Developmental Disability			
Epilepsy / Neurological Disorders			
Depression / Anxiety / Mental Illness			
Addiction			

Home Environment			
Who lives in the home? (Circle all that apply)	Mother	Father	Grandparent
	Sibling(s)		
	Other		
Is there more than one household?	No	Yes	
If yes	Joint custody	Single custody	Other
Does your house have a pool?	No	Yes	
If yes, does it have a self-locking gate/cover?	Yes	No	
Does anyone smoke in the house?	No	Yes	
Are there any guns in the home?	No	Yes	

If yes, are they locked up?	Yes	No	