Nature Coast Center for Primary Care

MEDICAL QUESTIONNAIRE: NEW PEDIATRIC PATIENT (page 1 of 2)

Patient Name: ____ Date of birth: ________________________
Mom's Name (or legal guardian): ____Maiden Name: _________________
Dad's Name (or legal guardian): ____

Immunizations: ◻ Up to date ◻ behind schedule ◻ limited ◻ No vaccinations

Birth Information:

Born at how many weeks?	By Vaginal or Cesarean delivery?	Birth Weight?	Birth Length?

Any complications of pregnancy or delivery? ____

Did your child: ◻ Go home with Mother **or** ◻ Require a stay in the NICU

Medications: List all medications (including over-the-counter and vitamins) that your child is currently taking:

Medication	Strength	Frequency	Last Dose

Allergies: Please list all of your child's allergies, including foods, along with the type of reaction:

Medication/Food	Type of Reaction

Surgeries: Please list all of your child's previous surgeries:

Date of Surgery	Type of Surgery	Any complications?

Hospitalizations: Please list all of your child's previous hospitalizations:

Date	Reason for Hospitalization

Medical problems: Please list all of your child's chronic illnesses and major health problems. Please include any specialist physicians involved in your child's care:

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Family history: Tell us about the health of your child's relatives. Include any serious illness (such as asthma, diabetes, depression, alcohol abuse etc.):

Family Member	Healthy	Medical conditions	Deceased (please include age and cause of death)
Father	◻		◻
Mother	◻		◻
Brother(s)	◻		◻
Sister(s)	◻		◻
Mother's mother	◻		◻
Mother's father	◻		◻
Father's mother	◻		◻
Father's father	◻		◻
Extended family (please list relation)	◻		◻

Social history: Tell us about your child's lifestyle/living environment:

Does your child smoke? ◻ Yes ◻ No Does anyone who lives with your child smoke? ◻ Yes ◻ No

Parent's Marital Status: ◻ Single ◻ Married ◻ Separated ◻ Divorced ◻ Remarried

Who does your child live with: ____

How many brothers?: _____ sisters?: ________

Does your child: ◻ go to day care ◻ stay home with mother, father or caregiver

◻ go to school: Grade _____________ School name: __________________________________

Special school services (such as IEP or therapy): ____________________________________

Do you have any concerns for your child's safety in any of these environments? ◻ Yes ◻ No

Diet: ◻ breastfed ◻ formula fed ◻ regular diet ◻ special diet____

Pets: _______________________________________

Concerns: What are your concerns today about your child's health?

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Review of symptoms: Please check <u>any</u> of the following symptoms that your child is having today:

1. ◻ fever ◻ weight/growth issues ◻ chills ◻ fatigue ◻ fussiness or irritability
2. ◻ sleeping problems ◻ behavior ◻ trouble at school ◻ depression ◻ anxiety
3. ◻ trouble eating ◻ difficulty swallowing ◻ stomach pain ◻ nausea or vomiting ◻ diarrhea ◻ constipation
4. ◻ trouble urinating ◻ bed wetting ◻ smelly urine ◻ pain when urinating ◻ frequent urination
5. ◻ discoordination ◻ seizures ◻ tremors ◻ headaches
6. ◻ runny nose ◻ post nasal drip ◻ seasonal allergies ◻ ear pain or discharge ◻ trouble hearing
7. ◻ eye pain ◻ trouble seeing ◻ cross eyes or "lazy" eye ◻ eye discharge
8. ◻ trouble breathing ◻ cough ◻ wheezing with or without exercise
9. ◻ heart trouble ◻ high blood pressure ◻ heart murmur ◻ chest pain
10. ◻ pain in joints, muscles or back ◻ weakness ◻ recent injury ◻ swelling anywhere
11. ◻ rashes ◻ moles ◻ lumps or bumps ◻ easy bruising ◻ acne
12. ◻ pain in genital area ◻ discharge in genital area ◻ menstrual or breast concerns

I have carefully reviewed this questionnaire and completed it to the best of my knowledge:

____ ________________________________

Signature of Patient, Parent or Legal Guardian (circle one) Date / Time