Pediatric New Patient Questionnaire

Name________________________________

Birth Date____________ Age ________ M_____ F_____

Today's Date_____________ Mother's Name_____________ Father's Name___________

Health Care Status, Past Illness & Hospitalizations

Where has your child gone for checkups until now? ____________________
What is the date of your child's last checkup? _____________________
What is the date of your child's last dental checkup? _________________
Is your child under treatment now for any illness or medical condition? __________________
Has your child had allergic reactions to any food, medications or bee stings? N____ Y_____
Has your child had a reaction to any immunizations? N______ Y______
Any hospitalizations other than birth? __________________Any surgeries? ____________________
Does your child take any over the counter medications regularly including Tylenol or vitamins? N___ Y_____ If yes, please list____
Circle any past illness': chickenpox, eczema, rheumatic fever, hay fever, asthma, convulsions, tonsillitis, tuberculosis, high lead, anemia, sickle cell, blood transfusions.

Pregnancy & Birth

Mother's age at birth of this child. _________
Did mother have any illness during pregnancy? N________ Y________
Did mother use any medications other than vitamins/iron? N______ Y______
Was the baby born on time? N______ Y_______
What was the baby's weight at birth? ___________
Did the baby have any trouble starting to breathe? N_______ Y_____
Did the baby have any trouble in the hospital (jaundice, infection, others)?_________________

Family History

Are the child's parents in good health? N_______ Y________
Circle any diseases that this child's mother, father, grandparents,, brother, sister, aunts, or uncles have had: anemia, asthma, allergies, diabetes, AIDS, high blood pressure, heart trouble, tuberculosis, mental illness, cancer, drug or alcohol problems, inherited illness', venereal disease.
Other_______________________________
List general health, age and sex of brothers and sisters.

Name	Age	Sex	Health

Have any of your children died? N____ Y_________

Feeding & Nutrition

Is your child's appetite usually good? N______ Y_______
Is it good now? N______ Y_________
Was there severe colic or any unusual feeding problems during the first 3 months of life? N___ Y__
Did any foods disagree with your child? N_____ Y_______
Is/was your child breast or bottle-fed or both? __________

If still on formula, which one do you use? ________________
Does your child take vitamins? N______ Y______

Development/Behavior
At what age did your child sit alone? ___________
At what age did your child walk alone? _____________
Did your child say any words by the time he/she was 11/2 years old? N______ Y_______
How does your child compare to other children his or her age. _______________________
Does your child have trouble sleeping? N_______ Y________
What grade is your child in? _______________
Has your child had trouble in school? N________ Y________
Does your child get along with other children? N_______ Y________
Circle if your child has any of the following: nail biting, thumb sucking, bed-wetting, nightmares, problems w/toilet training, bad temper, hyperactivity, speech problems, problems with discipline.

Safety & Environment
Do you live in private house, apartment, mobile home, other. (Please circle)
Do you know the hottest temperature of you hot water tank? N______ Y_______
Are there working smoke alarms on each floor where you live? N_______ Y_______
Does you child always use a seat belt/car seat in the car? N______ Y______
Are there any smokers in the home? N_____ Y_______
Are there any problems with the condition of your home, such as peeling paint, insects, rats or mice?
Does you child wear a helmet when riding a bike? N______ Y_________
Do you have firearms in the home? N_______ Y_________
Have any caregivers been trained in CPR? N________ Y_______
Do you have syrup of Ipecac in you home and the number for poison control? N_______ Y_______

Review of Systems
Has your child had frequent ear infections? N______ Y________
Has you child had any eye/vision problems? N_______ Y______
Has your child had any problems with their teeth? N______ Y_______
Does you child have frequent colds or sore throats? N________ Y______
Is there asthma, pneumonia or recurrent cough? N______ Y________
Does you child have a heart murmur or any heart problems? N_______ Y________
Any problems with urination? N_________ Y_________
Any problems with diarrhea or constipation? N_______ Y__________
Have there been any convulsions or other problems with the nervous system? N______ Y_______
Any eczema hives or skin condition? N_____ Y_________
Has your child ever been anemic? N_______ Y_______
Please list any other medical conditions. ____

Do you have a Record of immunizations? N________ Y__________
If yes, please give the immunization record to the nurse with this form.

Name of Person Completing this form: ___________________________
Relationship____________
Date __________ Physician's Signature______________________Date______

RIVER OAKS PEDIATRICS

PATIENT INFORMATION — PLEASE PRINT

Name of Patient____________________ Date____________
Home Address____________ City__________ State__________ Zip________
Home Phone____________________ Work/Cellular Phone____________________
Birthdate________________ Sex M F Social Security Number________________
Person Financially Responsible____________ Relationship__________ Phone__________
Emergency Contact____________________ Relationship__________ Phone__________

PRIMARY INSURANCE

Name of Insured____________________ Relationship____________________
Address if different from patient____________ City__________ State________ Zip________
Insured's Birthdate________________ Social Security Number________________
Insured's Employer____________________ Work Phone____________________

SECONDARY INSURANCE

Name of Insured____________________ Relationship____________________
Address if different from patient____________ City__________ State________ Zip________
Insured's Birthdate________________ Social Security Number________________
Insured's Employer____________________ Work Phone____________________

COPY OF INSURANCE CARD

AUTHORIZATION FOR TREATMENT

I authorize RIVER OAKS PEDIATRICS to provide medical treatment for ____________________, my child.

________________________________ ________________________________
Parent/Guardian Signature Date