Patient Name & DOB: ______________________________

NEW PATIENT MEDICAL HISTORY QUESTIONNAIRE

PLEASE REVIEW THE PROBLEM LIST AND ANSWER ACCORDINGLY FOR THE CHILD/PATIENT

PROBLEM	CIRCLE ONE	COMMENTS
Significant Birth History/Complications	YES or NO	
Serious Injuries or Accidents	YES or NO	
Surgeries	YES or NO	
Hospitalizations	YES or NO	
History of Chickenpox	YES or NO	
Frequent Ear Infections/Sinus Infections	YES or NO	
Pharyngitis/Tonsillitis	YES or NO	
Other Infectious Illnesses	YES or NO	
Food Allergies	YES or NO	
Rashes/Skin Problems	YES or NO	
Outdoor/Indoor Allergies	YES or NO	
Asthma/Wheezing	YES or NO	
Bronchiolitis, Pneumonia or Croup	YES or NO	
Sleep Apnea	YES or NO	
Heart Problems or Heart Murmur	YES or NO	
Hypertension	YES or NO	
Abdominal Pain or Reflux	YES or NO	
Chronic Diarrhea	YES or NO	
Constipation	YES or NO	
Bladder or Kidney Infections/ Urologic Problems	YES or NO	
Bedwetting (After Age 5)	YES or NO	

Patient Name & DOB: ________________________________

PROBLEM	CIRCLE ONE	COMMENTS
Eye Conditions/Corrective Lenses	YES or NO	
Problems with Ears or Hearing	YES or NO	
Chronic or Recurrent Skin Problems (Acne, Eczema, etc.)	YES or NO	
Anemia or bleeding problems	YES or NO	
History of Blood Transfusion	YES or NO	
Frequent Headaches	YES or NO	
Fainting	YES or NO	
Seizures	YES or NO	
Neurologic Disorders	YES or NO	
Mental Health Concerns	YES or NO	
ADD/ADHD	YES or NO	
Developmental Delays	YES or NO	
Muscle, Joint or Bone Problems	YES or NO	
Broken Bones	YES or NO	
Diabetes	YES or NO	
Thyroid or other Endocrine Problems	YES or NO	
Use of Alcohol or Drugs	YES or NO	
School/Learning/Behavioral Problems	YES or NO	
Emotional Problems	YES or NO	
If Female, Have menstrual periods started? If so, at what age?	YES or NO	
If Female, Are there any issues with periods?	YES or NO	
Any Other Significant Health Problems?	YES or NO	

PATIENT NAME: ___________________________________

NEW PATIENT FAMILY HISTORY QUESTIONNAIRE

PLEASE REVIEW THE PROBLEM LIST AND CHECK ANY FAMILY MEMBER THAT HAS THAT PROBLEM

PROBLEM	Natural Mother	Natural Father	Sibling (Specify)	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
Allergies Specify Type											
Anemia											
Asthma											
Attention Disorder Specify Type											
Birth Defects Specify Type											
Bleeding/ Clotting Disorder Specify Type											
Cancer Specify Type											
Crohn's/Colitis/ Intestinal Problems Specify Type											
Diabetes Specify Type											
Emotional Disorder Specify Type											
GERD											
Heart Attack Under Age 50											

PATIENT NAME: ______________________________

PROBLEM	Natural Mother	Natural Father	Sibling	Maternal G-Mother	Maternal G-Father	Maternal Aunt	Maternal Uncle	Paternal G-Mother	Paternal G-Father	Paternal Aunt	Paternal Uncle
High Blood Pressure											
High Cholesterol											
Kidney Disease											
Learning Disability Specify Type											
Developmental Disability Specify Type											
Migraines											
Peptic Ulcer											
Seizure											
Sudden Cardiac Death											
Sudden Infant Death Syndrome											
Tuberculosis											
Urinary Reflux											
Any Other Significant Family History Please be as specific as possible.											