ABC PEDIATRICS P.C.

NEW PATIENT QUESTIONNAIRE

TO BE FILLED OUT BY PARENT

Child's Name _____ Date _____

Mother's Name _____ Age _____

Occupation _____

Father's Name _____ Age _____

Occupation _____

If adults in the household work outside the home, what child care arrangements are made for this child? _____

_____

PAST MEDICAL HISTORY

1. Where has your child gone for check-ups until now? _____

2. Has your child had allergic reactions to any medications? **Yes** **No**
   foods, insect bites? **Yes** **No**
   Which ones? _____

3. Has your child had a reaction to any immunizations? **Yes** **No**
   Which ones? _____

4. Any hospitalizations other than for birth? **Yes** **No**
   For what? _____

5. Any serious injuries? **Yes** **No**
   What kind? _____

6. Are medications or vitamins taken regularly? **Yes** **No**
   Which ones? _____

7. Has your child had trouble meeting normal developmental milestones? **Yes** **No**

8. Please list any other medical problems: _____

_____

FAMILY HISTORY

1. Are the child's parents both in good health? **Yes** **No**

2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had:

asthma	diabetes	heart trouble	inherited illness	cancer	Anxiety	ADHD
allergies	high blood pressure	substance abuse	mental illness	AIDS	Depression	other _____

3. List age, sex, and general health of brothers and sisters _____

4. Have any of your children died? **Yes** **No**

Do you have a record of immunizations? **Yes** **No**

How did you hear about our office? _____

Are you new to the area? **Yes** **No**
If yes, circle one: Walker Wyoming