Lake Forest Pediatric Associates

New Patient Questionnaire

Today's Date _____

Name of Child _____ Date of Birth_____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

Birth history

Were there any complications during the pregnancy? No ❑ Yes ❑ Please give details:

Did mother take drugs or prescribed medications? No ❑ Yes ❑

Did mother smoke? No ❑ Yes ❑

Was the baby full term ❑ or premature ❑ how early?

Where was the baby born?

What was the birth weight?

Were there any complications of labor or delivery? No ❑ Yes ❑

Were there any newborn problems after birth? No ❑ Yes ❑ Please give details:

Name of Child _____ Date of Birth_____

Your Child's Health

Has your child ever been seen by a subspecialist? No ❑ Yes ❑

Do you consider your child to be in good health? No ❑ Yes ❑

Has your child ever been hospitalized overnight? No ❑ Yes ❑

Has your child ever had surgery? No ❑ Yes ❑

Has your child had any chronic or serious illnesses? No ❑ Yes ❑

Has your child had any major injuries? No ❑ Yes ❑

Is your child **allergic** to any medications? No ❑ Yes ❑

Is your child **allergic** to anything else? No ❑ Yes ❑

Is your child currently taking any medication? No ❑ Yes ❑

Are your child's immunizations [shots] current? No ❑ Yes ❑

Development

Has your child had any problems or delays in development? No ❑ Yes ❑

Does your child receive any therapy or any special services at school? No ❑ Yes ❑

Does your child have any behavioral or discipline problems? No ❑ Yes ❑

Has your child failed or repeated a grade in school? No ❑ Yes ❑

Past Medical History (Skip this section if your child is a newborn)

Does your child have or has he/she ever had:

Frequent ear infections No ❑ Yes ❑

Problems with ears or hearing No ❑ Yes ❑

Nasal allergies No ❑ Yes ❑

Problems with eyes or vision No ❑ Yes ❑

Asthma, bronchitis, or bronchiolitis No ❑ Yes ❑

Pneumonia No ❑ Yes ❑

Chickenpox or shingles No ❑ Yes ❑

Heart problem or murmur No ❑ Yes ❑

Anemia or bleeding problem No ❑ Yes ❑

Blood transfusion No ❑ Yes ❑

Frequent abdominal pain No ❑ Yes ❑

Name of Child _____ Date of Birth_____

Frequent constipation	No ❑ Yes ❑
Bladder or kidney infection or bedwetting	No ❑ Yes ❑
[for girls] has she started her menstrual periods?	No ❑ Yes ❑
[for girls] any problems with her periods?	No ❑ Yes ❑
Skin problems – eczema, acne	No ❑ Yes ❑
Frequent headaches	No ❑ Yes ❑
Seizures, convulsions, or epilepsy	No ❑ Yes ❑
Diabetes	No ❑ Yes ❑
Thyroid or other endocrine problems	No ❑ Yes ❑
Use of alcohol or drugs	No ❑ Yes ❑
Learning or attention problems	No ❑ Yes ❑
Any other significant problem	No ❑ Yes ❑

Your child's environment

Does anyone in the household smoke?	No ❑ Yes ❑
Does someone else care for your child during the day or after school?	No ❑ Yes ❑
Is your home childproofed?	No ❑ Yes ❑
Are there firearms in your home?	No ❑ Yes ❑
If yes, are they locked up?	No ❑ Yes ❑
Are there working smoke and carbon monoxide detectors at home?	No ❑ Yes ❑
Does your family always use seat belts / car seats?	No ❑ Yes ❑
Is anyone in your family getting hit or abused?	No ❑ Yes ❑
Has your child been exposed to anyone with tuberculosis?	No ❑ Yes ❑
Does your drinking water come from a well?	No ❑ Yes ❑
Are there any pets in the home?	No ❑ Yes ❑

Family Medical History

Has any blood relative on either side of the family had:		who?
Heart disease, or heart attack before age 50	No ❑ Yes ❑	
High blood pressure	No ❑ Yes ❑	
Elevated cholesterol or triglycerides	No ❑ Yes ❑	

Name of Child _____ Date of Birth_____

Diabetes or sugar problems	No ❑ Yes ❑
Cancer	No ❑ Yes ❑
Thyroid disease	No ❑ Yes ❑
Kidney disease	No ❑ Yes ❑
Asthma	No ❑ Yes ❑
Emphysema	No ❑ Yes ❑
Cystic fibrosis	No ❑ Yes ❑
Tuberculosis	No ❑ Yes ❑
Hepatitis	No ❑ Yes ❑
Cirrhosis	No ❑ Yes ❑
Ulcerative colitis	No ❑ Yes ❑
Crohn's disease	No ❑ Yes ❑
Bleeding or clotting disorder	No ❑ Yes ❑
Immune deficiency disorder	No ❑ Yes ❑
HIV or AIDS	No ❑ Yes ❑
Arthritis	No ❑ Yes ❑
Seizures or convulsions	No ❑ Yes ❑
Stroke	No ❑ Yes ❑
Neurologic disorder	No ❑ Yes ❑
Psychiatric disorder	No ❑ Yes ❑
Attention or learning disorder	No ❑ Yes ❑
Birth defects	No ❑ Yes ❑

Height of Father _____ Mother _____

_____ _____ _____

Person completing this form Signature Date

_____ _____ _____

Provider reviewing this form Signature Date

☐ Scan in to Chart