

NEW PATIENT QUESTIONNAIRE

Name: _____ Age: _____ yrs. Date of Birth: _____ Today's Date: _____

Primary Care Physician: _____ Referring Physician: _____

Mother's Name: _____ Home Phone: () _____

Address (if different from patient): _____

Occupation: _____ Work Phone: () _____

Father's Name: _____ Home Phone: () _____

Address (if different from patient): _____

Occupation: _____ Work Phone: () _____

What problem does your child have, and please explain: (where it is, when it started, if it is getting better or worse, any treatments tried, and anything else important) _____

Has your child had X-rays, MRI's, other studies or doctors visits for this problem? When, where, and who?

Birth: Normal (Vaginal) Cesarean **After Delivery:** Complications? _____

Presentation: Head first (Vertex) Foot first (Breech) _____

Birth Weight: _____ Length of hospitalization: _____

Development: Age sitting: _____ Age walking: _____

PT/OT/Speech/Bracing: _____ For girls: when menstrual periods started: _____

Medical History:

Other Medical Problems: _____

Prior Surgeries: _____

Medications: _____

Allergies: _____

Family History: Does anyone in the family have similar problems? _____

Is there anyone in the family with blood clots, problems with anesthesia, or easy bleeding? _____

Social History:

Current Grade in School: _____ Any special needs in school? _____

Sports: _____ Has school or sports been missed because of this problem? _____

Who lives at home with the patient: _____

Are any immediate family members deceased? _____

Review of Systems: (Circle all symptoms and explain if needed)

Constitutional	Fever	Chills	Weight Change	Other:
Eyes	Glasses	Vision Problems	Other:	
Ears, Nose, Mouth, Throat	Difficulties Hearing	Swallowing Problems	Speech Problems	Obstruction Drooling
Cardiovascular	Heart Problems	Circulation Problems		
Respiratory	Asthma	Difficulties Breathing	Apnea	Respiratory Treatments
Musculoskeletal	Bone Problems	Muscle Pains	Muscle Weakness	
Gastrointestinal	Stomach or Bowel Problems	Diarrhea	Constipation	
Genitourinary	Kidney Problems	Bed Wetting	Incontinence	Genital Problems
Skin/Breasts	Skin Problems	Breast Problems	Rashes	
Neurological	Seizures	Tremors	Weakness	Numbness
Psychiatric	Behavioral Problems	Psychiatric Disorders		
Endocrine	Diabetes	Thyroid Problems	Growth Hormone	
	Growth Delay	Other Hormone:		
Hematologic/Lymphatic	Easy Bleeding or Bruising	Clotting or Blood Disorders	Sickle Cell	
	Swollen Glands	Swollen Arms or Legs		
Allergic/Immunologic	Allergies	Immune Problems		

Reviewed and confirmed by: _____ Date: _____

