



New Patient Health Questionnaire

Name: _____

Date: _____

DOB: _____ M F

Form completed by/Relationship: _____

Household

Please list all those living in the home with your child

Name	Relationship to child	DOB	Health Issues - list

Are there siblings not listed? If so, please list names, ages & where they live. _____

Child lives with - if not with both biological parents:

- Mom Dad Joint custody single custody
 Adoptive Parents Foster Family

If one or both parents are not living in the home, how often does the child see the parents) not in the home? _____

Birth History Don't know birth history

Birth weight _____ Was baby term? _____ Or _____ # Weeks

Prenatal or neonatal complications? No Yes - explain: _____

NICU stay: No Yes - Explain: _____

During pregnancy, did mother-

- Take Pre-natal vitamins Prescription Medications: What & When _____
 Use drugs: _____ What & When _____ Use tobacco Drink alcohol

General: DK = don't know

Do you consider your child to be in good health? Yes DK No: Explain: _____

Does your child have any serious illness or medical conditions? No DK Yes - explain: _____

Surgery: None DK Yes-explain: _____

Hospitalizations: None DK Yes - explain: _____

Allergies to medications/drugs: None DK Yes - explain: _____

Do you feel your family has enough to eat? Yes DK No-explain: _____

Delivery: Vaginal Cesarean- why _____

Initial Feeding: Formula Breastfed - how long _____

Did baby go home with mother from hospital? Yes No - Explain: _____

Does your child have or ever had:				Explain
Chicken Pox	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	When: _____
Frequent ear infections	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with ears or hearing	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with eyes or vision	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Nasal Allergies	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Heart problems or Heart murmur	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Anemia or Bleeding disorder	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Received Blood transfusions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
HIV	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Cancer, Malignancy/ Bone Marrow Transplant	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Chemotherapy	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Organ Transplant	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Kidney disease or urologic malformations	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Bed-wetting after age 5	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Recurrent Urinary tract infections & problems	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Frequent Abdominal pain	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Constipation requiring doctor visits	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Metabolic/Genetic disorders	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Developmental delay or disability	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Sleep problems - Snoring	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Chronic or recurrent skin issues - eg: acne/eczema	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Frequent Headaches	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Convulsions or other neurologic problems	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Obesity	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Diabetes	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Thyroid or Endocrine issues	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
High Blood Pressure	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
History of serious injuries/fractures, concussions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Use of Alcohol, Drugs, Tobacco	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Dental Decay	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
History of family violence	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Sexually transmitted infections	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
For Girls:				
Has had first period	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Problems with periods	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Pregnancy	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes	_____
Any other significant problems?				_____

Biological Family History

Any family members with the following?				Who	Comments
Childhood hearing loss	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Nasal Allergies	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Asthma	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Tuberculosis	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Heart Disease before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
High Cholesterol- on medication	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Anemia	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Bleeding disorder	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Dental Decay	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Cancer - before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Liver disease	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Kidney disease	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Diabetes - before age 55	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Bed-wetting after age 10	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Obesity	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Epilepsy or convulsions	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Alcohol abuse	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Drug abuse	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Mental Illness/depression	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Developmental disability	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Immune problems, HIV or AIDS	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Tobacco Use	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		
Additional Family history	<input type="checkbox"/> No	<input type="checkbox"/> DK	<input type="checkbox"/> Yes		

If there are multiple children in a family- copy page three and only complete one time.

This New Patient Health Questionnaire is consistent with American Academy of Pediatrics
& Bright Futures: Guidelines for Health Supervision of Infants, Children & Adolescents.