New Patient Questionnaire
(To be completed by parent or guardian)

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Today's date:_____
Patient's name:_____ Date of birth_____
Siblings and birthdates_____

Mother's name:_____ Father's name:_____
Mother's occupation:_____ Father's occupation:_____

Birth History
Birth Hospital_____
Complications during pregnancy?_____
Complications during delivery?_____

Past Medical History
List hospitalizations _____
List surgeries/procedures_____
List specialists child has been seen by:_____

Allergy History
Medication allergies_____Reaction_____
Environmental allergies_____Reaction_____

Family History
Family history of illness? __yes __no
If yes, list family member and illness_____

Social History
Are mom and dad married? __yes __no
Who lives in the home?_____
Does anyone in the home smoke? __yes__no If yes, who smokes?_____
For 13 year olds and up, is patient a smoker? __yes __no
School or daycare? __yes __no Where?_____
Are there pets in the home? __yes __no If yes, how many and what kinds_____
Is there domestic or physical violence in the home? __yes __no
Does the patient use protective gear during sports? __ yes __no

Current History
Is the patient currently taking any medications? __yes ___no
If yes, name of medication and dosage_____
Any current concerns?_____