The Christ Hospital™ Health Network

Primary Care
PEDIATRIC NEW PATIENT QUESTIONNAIRE

Patient Name _____ **Date of Birth** _____

❑ Male ❑ Female

Father _____ Mother_____

Best phone number to reach you_____ Alternate # _____

Pharmacy_____ Pharmacy phone # _____

Pharmacy address _____

Birth History

Problems during the pregnancy: ❑ No ❑ Yes_____

Alcohol, tobacco or drug usage during pregnancy ❑ No ❑ Yes _____

Delivery

❑ On time ❑ Premature – how early_____ ❑ Overdue - how late _____

❑ Normal delivery ❑ C-section ❑ Breach ❑ Forceps ❑ Vacuum

❑ Problems with delivery _____

❑ Problems after delivery _____

Birth weight: _____ Birth length: _____

Feeding: ❑ Breastfeeding ❑ Bottle: ❑ Breastmilk ❑ Formula Formula Name _____

Medical Problems

❑ Birth Defects
❑ Developmental Delay
❑ ADD/ADHD
❑ Diabetes
❑ Allergies
❑ Eye Problems
❑ Anemia
❑ Heart Problems
❑ Asthma
❑ Hearing Problems
❑ Bed Wetting
❑ Hepatitis
❑ Broken Bones
❑ Sickle Cell Disease
❑ Chicken Pox
❑ Skin Problems
❑ Constipation
❑ Speech Problems
❑ Depression/Anxiety

Medications

Please list both prescription and non-prescription medications you are currently taking:

Medication	Dose	Times/day	Medication	Dose	Times/day

Patient Name _____ **Date of Birth** _____

Allergies

Do you have any drug or environmental allergies? ❑ No ❑ Yes If YES, please list below and describe reaction.

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

_____ Reaction: _____

Surgical History (List any surgeries you have had in the past & date of surgery)

- ❑ Appendix _____
- ❑ Tonsils _____
- ❑ Adenoids _____
- ❑ Cancer _____
  Type _____
- ❑ Circumcision _____
- ❑ Hernias _____
- ❑ Joint Surgeries:
  Type & Date _____
- ❑ Testicle Surgery _____
- ❑ Tubes in Ears _____
- ❑ Other _____

Family Medical History – Please list relationship of family members who have/had any of the following conditions.

- ❑ Cancer _____
- ❑ Asthma _____
- ❑ Stroke _____
- ❑ HIV/AIDS _____
- ❑ Diabetes _____
- ❑ Arthritis _____
- ❑ Seizures _____
- ❑ Migraines _____
- ❑ Heart Problems _____
- ❑ High Cholesterol _____
- ❑ Skin Problems _____
- ❑ Kidney Disease _____
- ❑ High Blood Pressure _____
- ❑ Thryoid Disease _____
- ❑ Clotting Disorder _____
- ❑ Alcoholism _____

Patient Social History

Daycare	❑ No	❑ Yes
Pets in home	❑ No	❑ Yes
Live with smokers?	❑ No	❑ Yes

Physician/Provider Signature: _____ **Date:** _____