grand traverse children's clinic

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New Patient Questionnaire

Patient's Name: _____ _____ _____ DOB: _____
Last *First* *MI*

Pregnancy and Birth

		Birth Weight: _____lbs. _____oz.
No	Yes	Any complications of pregnancy or delivery?
No	Yes	Did baby come home with mom from hospital?
No	Yes	Did baby have any trouble breathing?
No	Yes	Did baby have any trouble in the hospital?

Review of Systems

		Does your child have…
No	Yes	…frequent ear infections?
No	Yes	…any eye problems?
No	Yes	…frequent colds or sore throats?
No	Yes	…Asthma, pneumonia, or recurrent cough?
No	Yes	…a heart murmur or heart problems?
No	Yes	…diarrhea or constipation?
No	Yes	…convulsions, seizures, or other nervous system issues?
No	Yes	…Eczema, hives, or other skin conditions?
No	Yes	…Anemia

Past Medical History

		Has or does your child…
No	Yes	…see any specialists?
No	Yes	…been hospitalized?
No	Yes	…have regular dental care?
No	Yes	…had allergic reactions to any medications, foods, or insects?
No	Yes	…had reactions to any immunizations?
No	Yes	…had any surgeries?
No	Yes	…take any medications regularly?
No	Yes	…have any developmental concerns?

Family History

No	Yes	Are the child's parents in good health?
No	Yes	Are any of your children deceased?

***Explain any "Yes" responses:*

***Check any diseases that the child's Parents, Grandparents, Brothers, Sisters, Aunts, or Uncles have or had:*

	Anemia		High Blood Pressure		Mental Illness		Venereal Disease
	Asthma		Heart Trouble		Drug Problems		AIDS
	Allergies		Cancer		Alcohol Problems		Tuberculosis
	Diabetes		Inherited Illness				

Others: