Date of visit:___________________ Name:____

DIVISION OF PEDIATRIC OTOLARYNGOLOGY NEW PATIENT QUESTIONNAIRE	TO BE FILLED OUT BY PARENT OR CAREGIVER

Mother's name ____

Occupation ____

Father's name ____

Occupation ____

A. PREGNANCY AND BIRTH:

1. Mother's age at birth ___________
2. Did mother have any illness during pregnancy? No Yes
3. Did she take any medications other than vitamins and iron supplements? No Yes
4. Was the baby on time? Yes No
5. What was the birthweight? ___________
6. Did the baby have any trouble breathing? No Yes
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes
   What kind? ____
   ____

B PAST MEDICAL HISTORY:

1. Does your child have a regular pediatrician? Yes No
   Who? ____
2. Has your child had allergic reactions to any medications, foods, or insect bites? No Yes
   Which ones? ____
3. Any hospitalizations other than for birth? No Yes
   For what? ____
4. Any serious injuries? No Yes
   What kind? ____
5. Are any medications taken regularly? No Yes
   Which ones?____

C. FAMILY HISTORY

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, others
3. List age, sex, and general health of brothers and sisters ________
   ____
   ____
4. Have any of your children died? No Yes

D. NUTRITION AND IMMUNIZATIONS

1. Is your child's appetite usually good? Yes No
2. Does he/she take vitamins? Yes No
3. Is your child up-to-date on immunizations? Yes No

If adults in the household work outside the home, what child care arrangements are made for this child? _________________________
____

E. REVIEW OF SYSTEMS:

a. Has your child had frequent ear infections? No Yes
b. Any eye problems? No Yes
c. Does he/she have frequent colds or sore throats? No Yes
d. Is there asthma, pneumonia, or recurrent cough? No Yes
e. Does he/she have a heart murmer or any heart problems? No Yes
f. Any problems with urination? No Yes
g. Any problems with diarrhea or constipation? No Yes
h. Have there been any convulsions or other problems with the nervous system? No Yes
i. Any eczema, hives, or other skin conditions? No Yes
j. Has your child ever been anemic? No Yes
k. Please list any other medical problems: _______________________
   ____

F. DEVELOPMENT/BEHAVIOR:

1. At what age did your child sit alone? ___________
2. At what age did he/she walk alone? ___________
3. Did he/she say any words by the time he/she was 1½ years old? Yes No
4. Does he/she have any trouble sleeping? No Yes
5. Has he/she had any trouble in school? No Yes
6. Circle if your child has had any of the following: thumb sucking, bed wetting, bad temper, hyperactivity, nightmares, speech problems, other

G. SAFETY/ENVIRONMENT:

1. Do you live in a private house, apartment, other? (CIRCLE)
2. Do you know the hottest temperature of the water in your pipes? Yes No
3. Is there a working smoke alarm on each floor? Yes No
4. Does your child always use a car seat/seat belt when riding in a car? Yes No
5. Does your child always wear a helmet when riding his/her bicycle? Yes No

Please do not write below this line. Thank you!

Reviewed & Updated by Physician: Signature & Date	

SUNY DOWNSTATE Medical Center
University Hospital of Brooklyn

UNIVERSITY PHYSICIANS BROOKLYN, INC.

Office location: ☐ UPB-ENT 185 Montague St ☐ UPB-ENT 376 6th Ave ☐ SUNY Suite H

DIVISION OF PEDIATRIC OTOLARYNGOLOGY **REGISTRATION RECORD**	**TO BE FILLED OUT BY PARENT OR CAREGIVER**

CHILD'S NAME ____ ☐ BOY ☐ GIRL
LAST FIRST MIDDLE

CHILD's BIRTHDATE ____________________ CHILD'S SOCIAL SECURITY #____________________

MOTHER / FATHER / PARENT ______________________________ BIRTHDATE ______________

MOTHER / FATHER / PARENT______________________________ BIRTHDATE ______________

HOME ADDRESS ______________________________________ APARTMENT # ___________

CITY, STATE ____ ZIP CODE ______________

HOME PHONE ________________________ CELL PHONE or BEEPER ________________________

WORK PHONE (Mom/Parent) _____________ WORK PHONE (Dad/Parent) ________________________

Email Address (Mom/Parent)

____

Email Address

(Dad/Parent)____

PHARMACY NAME ________________________ PHARMACY PHONE #_________________________

PHARMACY NAME ADDRESS ____

INSURED'S NAME ____
LAST FIRST MIDDLE

INSURED'S DATE of BIRTH __________________ SOCIAL SECURITY # ________________________

EMPLOYER NAME ____

EMPLOYER'S ADDRESS ____

PRIMARY INSURANCE______________________________ POLICY # ________________________

OTHER INSURANCE ______________________________ POLICY # ________________________

My signature below indicates that I am requesting care in this office and consent to medical treatment. I authorize Dr. _______________ to release medical information to the primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I have insurance coverage with the above named company and assign directly to the physician all surgical and/or medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all chanrges whether or not paid by insurance.

SIGNATURE ____ DATE ______________________

RELATIONSHIP to PATIENT______________________________

How did you hear about our practice?

☐ by primary care physician
☐ by a different physician
☐ by a friend or relative or colleague
☐ by insurance or managed care program
☐ Practice Website
☐ ZocDoc
☐ Newspaper/Magazine
☐ Internet (Google,Bing,Yelp, etc)
☐ Other

NAME OF REFERRAL SOURCE (if applicable) ____

PRIMARY CARE PHYSICIAN ____

ADDRESS ____ PHONE ____________________