



Kids First Pediatric Clinic, LLC
 1673 10th Street, West Linn, OR 97068
 Phone: (503) 699-3313 Fax: (971) 229-4678
 www.kidsfirstclinic.com

NEW PATIENT QUESTIONNAIRE

Patient's Name _____ DOB: _____ Today's Date _____

Mother's Name _____ Age _____ Father's Name _____ Age _____

PREGNANCY AND BIRTH

Mother's at child's birth _____

What number pregnancy was this child? _____

Did mother have any illness during pregnancy? Y N

Did she take any medications other than vitamins and iron? Y N

If yes, what? _____

Was the baby on time? Y N

If no, how early was your baby? _____

Were there any complications with the baby during delivery? _____

Was the delivery **vaginal** or by **C-section**? _____
 Y N

Did the baby go home at the same time as mom?

Did the baby have any trouble while in the hospital?
 (Jaundice, Infections, other?) _____

Did the baby go to the NICU? Y N

If yes, please give a brief synopsis of the course:

If so, how long were they there? _____

If on ventilator, how long? _____

If on oxygen, how long? _____

Other info (infections, surgeries, interventions) while in NICU:

Birth Weight _____ Birth Length _____

Are your child vaccinations up to date? Y N

If not, why? _____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y/N

Was there severe colic or any unusual feeding problems during the first 3 months? Y/N

Do any foods disagree with him/her? Y/N

If so, what? _____

For the first 6 months, is (s)he was breast-fed or bottle-fed?

If still on formula, which one? _____

Does (s)he take vitamins? Y/N

DEVELOPMENT/BEHAVIOR

How does child compare to others of same age?

Does child have any of the following? (circle all that apply)

Thumb sucking

Nail biting

Bed wetting

Bad temper

Problems with toilet training

Hyperactivity

Problems with discipline

Nightmares

Speech problems

Other _____



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Has your child had any of the following medical problems? Please circle one

- Serious injuries or accident
- Hospitalization
- Surgeries
- Chickenpox disease
- Hearing loss
- Anemia or bleeding problem
- Kidney problem
- Eczema
- Learning disorder
- Frequent ear infection
- Heart problem or murmur
- Blood transfusion
- Bladder or kidney infection
- Bedwetting (after 6 years of age)
- Use of alcohol or drugs
- Constipation requiring Dr. Visits
- Asthma/ wheezing/ pneumonia
- Allergies-seasonal, animals, indoor, foods
- Allergic reactions- medications, vaccinations
- Frequent headaches, convulsions of other neurological problems
- Diabetes/ blood sugar problems
- Thyroid or other endocrine problems
- Other significant problems

PAST MEDICAL HISTORY

- Where has your child gone for check-ups until now?

- Date of last Check-up

- Date of last dental check-up

- Are any medications taken regularly? Y N
- Please list names, dosages and frequency taken?

- If female, have periods started?

- When? _____

FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins or grandparents)

- | | |
|---|-----------------------|
| Spina Bifida | vision/eye problems |
| Bone disorder | cerebral Palsy |
| Cleft lip/palate | ADD/learning disorder |
| Hearing loss/deafness | Convulsions |
| Heart disease/defect | Infertility |
| Neurofibromatosis | Limb defects |
| Mental retardation | Down Syndrome |
| Neurological disorder | Cystic fibrosis |
| Mental Illness | Short stature (<5ft) |
| Tuberculosis | Diabetes |
| Hay fever/allergies | Drug/alcohol problems |
| Sickle Cell Anemia | Bleeding disorder |
| Muscle disorder | Kidney disease |
| Skin disease | Genital abnormality |
| High blood pressure | Asthma |
| Urinary tract abnormality | AIDS (HIV) |
| High cholesterol/triglycerides | |
| Chromosome abnormality | |
| Brain anomalies (includes Hydrocephaly) | |
| Anemia (includes Thalassemia) | |
| Patient's mother was exposed to DES | |
| Other birth defect/malformations/problems? | |
| Please list: _____ | |
| _____ | |
| List age, sex, and health problems of brothers and sisters (are they living)? | |
| _____ | |
| _____ | |