PEDIATRIC ASSOCIATES OF LANCASTER

1550 Sheridan Drive • Suite 102 • Lancaster, Ohio 43130-1303

NEW PATIENT QUESTIONNAIRE

CHILD'S NAME _____ DATE OF BIRTH _____

PREVIOUS PHYSICIAN _____ TODAY'S DATE _____

LAST SEEN _____

PREGNANCY:

1) Mother's age @ birth of child _____
2) Any illness during pregnancy? No Yes
3) Take any medications except vits/iron? No Yes
   What: _____

LABOR:

1) Vaginal or C-section
2) Problems with labor? No Yes

NEWBORN:

1) Was baby on time? No Yes
2) Birth weight _____
3) Circle any problems:
   Blueness Breathing Jaundice Infection Eating
4) Where was baby born?

PAST MEDICAL HISTORY:

1) Allergies to medication? No Yes
   If so, what? _____
2) Hospitalization? No Yes
   If so, what? _____
3) Surgery? No Yes
   If so, for what? _____
4) Chronic medical problems? No Yes
5) Serious injury? No Yes
6) Routine Medications? No Yes
7) Immunizations up-to-date? No Yes

FAMILY HISTORY:

	Age	Health Problem
1) Child's Father's Name		
Child's Mother's Name		
Child's Brother/Sister		

1) Circle any disease in immediate family member (parent, grand-parent, brothers, sisters, etc):

   Anemia Allergy Diabetes Asthma High Blood Pressure
   Heart trouble Tuberculosis Mental Illness Drug Usage
   Alcohol problems STD Cancer AIDS Epilepsy
   Bleeding problems High Cholesterol Heart disease under 50
   ADHD

REVIEW OF SYSTEMS:

1) Does your child have:

Trouble seeing	No	Yes
Crossed eyes	No	Yes
Frequent ear infections	No	Yes
Trouble Hearing	No	Yes
Heart Murmur	No	Yes
Chronic Cough	No	Yes
Frequent abdominal pain	No	Yes
Frequent urinary tract infection	No	Yes
Other problems?	No	Yes

SAFETY: (circle)

1) Do you live in a: house apartment mobile home
   other _____
2) Are there smokers in the house? No Yes
3) Is there a smoke alarm on each floor? No Yes
4) Are there any problems with the condition of your home:
   (peeling paint, insects, rates/mice) No Yes
5) How old is your home? _____