



New Patient Medical Questionnaire

Patient Name _____ DOB _____
Person Filling Out This Form? (circle): Patient Mother Father Other: _____

Please circle one. If YES, please explain in the lines provided to the right.

A. PREGNANCY AND BIRTH: (skip for adults)

1. Did mother have any illness during pregnancy? No Yes _____ Vaginal or cesarean? _____
2. What was the birth weight? _____
3. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No Yes _____

B. PAST MEDICAL AND SURGICAL HISTORY:

1. Any serious past medical problems? No Yes _____
2. Any past surgery? No Yes _____ Date(s): _____
3. Any problems with anesthesia? No Yes _____
4. Any problems with bleeding after surgery? No Yes _____
5. Date of last checkup: _____
6. Any **allergic reactions** to any medications, foods? No Yes _____ Type of reaction: _____
7. Any hospitalizations? No Yes _____
8. **Regular medications?** No Yes (please list) _____

9. Has the patient had any of the following?

- | | |
|---|---|
| Ear problems? No Yes _____ | High blood pressure? No Yes _____ |
| Eye problems? No Yes _____ | Problems with teeth? No Yes _____ |
| Asthma, pneumonia? No Yes _____ | Heart problems? No Yes _____ |
| Problems with urination? No Yes _____ | Gastrointestinal problems? No Yes _____ |
| Convulsions/central nervous system problems? No Yes _____ | Skin conditions? No Yes _____ |
| Kidney problems? No Yes _____ | Depression, anxiety, ADHD? No Yes _____ |

C. FAMILY HISTORY:

Please check if mother (M), father (F), siblings (S), maternal or paternal grandparent (MGF, MGM, PGF, PGM.)
 had any: Birth defect _____ High Blood Pressure _____ Cystic fibrosis _____ Sickle cell _____
 Diabetes _____ Bleeding disorder _____ Kidney disease _____ Obesity _____
 Cancer _____ Thyroid disease _____ High Cholesterol _____

D. SOCIAL HISTORY:

1. Does the patient live with: Mother _____ Father _____ Both _____ Other _____
2. How many siblings at home? _____ Any one sick at home? No Yes _____
3. What grade if in school: _____ Name of school: _____ Sports: No Yes _____
4. Occupation (if any): _____ Any secondhand smoke exposure or smoking? No Yes _____
5. Any recreational drugs? No Yes _____ Regular Alcohol intake? No Yes _____

Patient/Parent signature _____ Date: _____