Washington University Physicians

New Patient Questionnaire

Today's Date ____________

To Be Filled Out By Parent

Child's name ________________________________ Birth Date ________ Referred by __________

Mother's name________________________________ Age _______

Occupation ________________________________

Father's name ________________________________ Age _______

Occupation ________________________________

If Adults in the household work outside the house, what child care arrangements are made for this child?

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			If "yes", please explain
Pregnancy And Birth			
Mother's age at birth			
Was the baby on time?	Y	N	
What was the birth weight?			
Did the baby have any trouble while in the hospital? (jaundice, infection, other) What kind?	Y	N	
Past Medical History			
Has your child had any allergic reactions to food, medications?	Y	N	
Any hospitalization?	Y	N	
Any serious injuries?	Y	N	
Are any medications taken regularly?	Y	N	
Ever had surgery?	Y	N	
Is your child missing any vaccines?	Y	N	
Review Of Systems			
Has your child had frequent ear infections?	Y	N	
Any eye problems?	Y	N	
Does he/she have frequent colds or sore throats?	Y	N	
Is there asthma, pneumonia, or recurrent cough?	Y	N	
Does he/she have a heart murmur or any heart problem?	Y	N	
Any problems with urination?	Y	N	
Any problem with diarrhea or constipation?	Y	N	
Have there been any convulsions or other problems with nervous system?	Y	N	
Any eczema, hives, or other skin conditions?	Y	N	
Has your child ever been anemic?	Y	N	
Please list any other medical problems			
Has your child's development been abnormal or delayed in any way?	Y	N	

Family Medical History for Children

Family Medical History: Concerning illnesses or medical conditions of family members (not your child), please think about your child's brother, sister, parents, grandparents, aunts, and uncles. Do any of those family members have any of the following conditions? You may use following abbreviations if you like:

M=mother, **F**=father, **GM**=grandmother, **GF**=grandfather, **B**=brother, **S**=sister, **A**=aunts, **U**=uncle

Medical Condition			**Relationship to Your Child**
Hip problems or dislocated hip at birth?	Y	N	
Complete deafness or hearing loss before age of 10?	Y	N	
Vision problems under age of 8?	Y	N	
Developmental delay?	Y	N	
Premature death in the family?	Y	N	
Deaths in infants or young children?	Y	N	
Severe allergies or hay fever?	Y	N	
Asthma or recurrent wheezing?	Y	N	
Seizure or diseases of nerves or muscles?	Y	N	
Migraine headaches?	Y	N	
Cancers before age 40 (note type)?	Y	N	
High blood pressure?	Y	N	
Heart attacks / strokes, pacemaker or any other heart problems before age 50?	Y	N	
High cholesterol (above 240 mg/dl)?	Y	N	
Thyroid or other endocrine problem?	Y	N	
Inflammatory bowel or serious bowel disease?	Y	N	
Major depression / psychiatric problem (note type)?	Y	N	
Attention deficit disorder or learning problems?	Y	N	
Bleeding problems?	Y	N	
Kidney problems?	Y	N	
Any other problems of importance?	Y	N	