

**USF Pediatric Clinic
New Patient Questionnaire
(Birth through 10 years)**

Patient Name:	<input type="checkbox"/> M <input type="checkbox"/> F	DOB:
ALLERGIES	CURRENT MEDICATIONS	
Drug:	Prescription:	
Food:		
Other:		

YOUR NAME: _____ **RELATIONSHIP TO CHILD:** _____

HOW LONG HAS THE CHILD BEEN IN YOUR CARE: _____

MOTHER'S NAME: _____ **FATHER'S NAME:** _____

Address (if different from registration form): _____

Who lives in the home with the child? Number of adults: _____ **Number of children:** _____
(Please list names and ages of brothers and sisters)

NAME: _____ **NAME:** _____
NAME: _____ **NAME:** _____

PETS: _____ **TYPE:** _____

SMOKERS INHOUSEHOLD: Yes No **Who:** _____

WATER SOURCE: City Well Bottled County

PRENATAL AND DELIVERY HISTORY	FAMILY HISTORY		
During Pregnancy did you use:	CHECK IF BLOOD RELATIVES HAVE THE FOLLOWING:		
Street Drugs: <input type="checkbox"/> yes <input type="checkbox"/> no		YES	NO
Alcohol: <input type="checkbox"/> yes <input type="checkbox"/> no	Asthma		
Tobacco/Smoking: <input type="checkbox"/> yes <input type="checkbox"/> no	Sickle Cell Disease		
Illnesses During Pregnancy:	Cystic Fibrosis		
Meds During Pregnancy:	Tuberculosis		
Birth Weight: Length:	Kidney Infections		
Type of Delivery:	Diabetes		
Place of Birth/Hospital:	Hyperactivity		
Newborn Complications/Problems:	Mental Retardation		
How Long was the Pregnancy?	Sudden Death		
	Birth Defects		
	Other		

PAST HISTORY											
Recurrent Ear Infections	yes	no	Urinary Tract Infections	yes	no	Sickle Cell Anemia/Blood Disorder:					
Frequent Colds/Sore Throat	yes	no	Chicken Pox	yes	no		Year:	Yes	no		
Asthma /Bronchitis	yes	no	Injuries I.e. broken bones/stitches	yes	no	Seizures	yes	no			
Tonsillitis	yes	no	Blood Transfusion (s)	yes	no	Stomach Problems	yes	no			
Allergies	yes	no	Lead Poisoning	yes	no	Heart Murmur	yes	no			
Bed Wetting	yes	no	Surgeries	yes	no	Diabetes	yes	no			
Last TB Screening:	Pos	Neg	Age Performed:			Hospitalization (s)	yes	no			
Immunization up to date?			<input type="checkbox"/> Yes			<input type="checkbox"/> No					<input type="checkbox"/> Don't know
Immunization record available today?			<input type="checkbox"/> Yes			<input type="checkbox"/> No	(If no, bring at next visit)				

SOCIAL AND BEHAVIORAL

Primary Language:				
Translation/Hearing Impaired Needs:				
Grades/Grade in School:				
Performance in School:				
Circle all that apply:	Daycare	Preschool	Sports	After-School Care
AGES 8 YEARS AND UP				
Do you smoke?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, number of years:	How much each day:
Drinks alcohol?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, amount/day:	Amount / week:
Take street drugs or smoke marijuana?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Sexually active?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Using Contraceptive?	<input type="checkbox"/> Yes <input type="checkbox"/> No

DOES YOUR CHILD HAVE PROBLEMS WITH:	YES	NO	DON'T KNOW	COMMENTS
Frequent Nightmares				
Difficult to Control				
Problem Behavior in School				
Fighting a Lot				
Trouble Making Friends				
Vision/Hearing Problems				
Appetite				
Bedwetting / Stooling				
Other Concerns you have:				

GROWTH AND DEVELOPMENT

AGE EXPECTED	PHYSICAL	AGE	SOCIAL	AGE	COMMUNICATION	AGE
0-3 mos	Holds head up		Smiles		Coos	
4-6 mos	Rolls over		Reaches for objects		Laughs	
7-10 mos	Sits alone		Drinks from cup		Babbles	
11-15 mos	Walks		Scribbles		First words	
16-24 mos	Jumps in place		Feeds self		Combines two words	
2-3 yrs	Broad jump		Toilet trained		Uses sentences	
4-5 yrs	Catches ball		Dresses self		Tells story	
6-8 yrs	Jumps rope		Draws triangle		Reads words	
9-10 yrs	Rides bicycle		Does household chores		Tells time	

Name, Telephone Number and Address of Previous Doctor: _____

Completed by: _____ Date: _____

Doctor Signature: _____ Date: _____