

**USF Pediatric Clinic  
New Patient Questionnaire  
(11 through 21 years)**

<b>Patient Name:</b>	<b>M</b>	<b>F</b>	<b>DOB:</b>
<b>ALLERGIES</b>	<b>CURRENT MEDICATIONS</b>		
<b>Drug:</b>	<b>Prescription:</b>		
<b>Food:</b>			
<b>Other:</b>			

**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: \_\_\_\_\_

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

**FOR FEMALES ONLY**

<b>Age at onset of period:</b>	<b>Frequency:</b>	<b>Length of period:</b>
<b>Pregnancies:</b>		
<b>Births:</b>		
<b>Miscarriages:</b>	<b>Abortions:</b>	
<b>Have you ever had a Pap Smear?</b>	Yes No	<b>If yes – Date:</b> _____ <b>Result:</b> _____

**SOCIAL AND BEHAVIORAL**

Primary Language: \_\_\_\_\_

Translation/Hearing Impaired Needs: \_\_\_\_\_

School Name: \_\_\_\_\_

Grades/Grade in School: \_\_\_\_\_

Performance in School: \_\_\_\_\_

**AGES 8 YEARS AND UP**

Do you smoke?      Yes      No      If yes, number of years:      How much each day:

Drinks alcohol?      Yes      No      If yes, amount/day:      Amount / week:

Take street drugs or smoke marijuana?      Yes      No

Sexually active?      Yes      No      Using Contraceptive?      No      Yes      Type: \_\_\_\_\_

DOES YOUR CHILD HAVE PROBLEMS WITH:	YES	NO	DON'T KNOW	COMMENTS
Frequent nightmares				
Difficult to control				
Hyperactivity/bad temper				
Problem behavior in school				
Copes with stress				
Trouble making friends				
Vision/Hearing problems				
Appetite/Eating problems (If yes describe.)				
Gets along with peers				
Socially withdrawn or depressed a lot of the time				
Height or Weight				
Exercise/sports activities				
Regular school attendance				
Expresses ideas for future plans				
Other concerns you have:				

**PAST HISTORY**

Recurrent Ear Infections	yes	no	Urinary Tract Infections	yes	no	Sickle Cell Anemia/Blood Disorder:	Yes	no
Frequent Colds/Sore Throat	yes	no	Chicken Pox	yes	no		Year:	
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
Tuberculosis	yes	no	Alcohol/Drug Problems	yes	no	Abuse	yes	no
Hepatitis	yes	no	HIV/Aids	yes	no	Headaches	yes	no
Depression	yes	no	Suicide/suicide attempts	yes	no	Learning problems	yes	no
Last TB Screening:	Pos	Neg	Age Performed:			Hospitalization (s)	yes	no
<b>IMMUNIZATION UP TO DATE?</b>			<b>YES</b>			<b>NO</b>	<b>DON'T KNOW</b>	
<b>IMMUNIZATION RECORD AVAILABLE TODAY?</b>			<b>YES</b>			<b>NO</b>	<b>(If no, bring at next visit.)</b>	

Name, Telephone Number and Address of Previous Doctor: \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_

Doctor Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(That reviewed.)