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

Patient Name:	☐ M ☐ 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 IN HOUSEHOLD: ☐ Yes ☐ No Who:________________

PRENATAL AND DELIVERY HISTORY	FAMILY HISTORY			
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:	Diabetes			
Place of Birth/Hospital:	Hyperactivitiy			
Newborn Complications/Problems:	Mental Retardation			
How long was the Pregnancy?	Sudden Death			
	Birth Defects			
	Other			

FOR FEMALES ONLY		
Age at onset period:	Frequency:	Length of period:
Pregnancies:		
Births:		
Miscarriages:	Abortions:	
Have you ever had a Pap Smear? ☐ Yes ☐ No	If yes - Date:	Result:

SOCIAL AND BEHAVIORAL
Primary Language:
Translation/ Hearing Impaired Needs:
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?	☐ Yes ☐ No

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Socially withdrawn or depressed a lot of the time				
Normal height & 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/Drugs 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
IMMUNIZATION UP TO DATE?		☐ **YES**	☐ **NO**	☐ **DON'T KNOW**	
IMMUNIZATION RECORD AVAILABLE TODAY?		☐ **YES**	☐ **NO** (if no, bring at next visit)		

Name, Telephone Number and Address of previous Doctor: ____

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Complete by: ____ Date: ____________________________

Doctor's Signature: _______________________________________ Date: ____________________________