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

Patient Name:	☐ **M** ☐ **F**	**DOB:**
Allergies	**Current Medication**	
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:** ____________________

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: ☐ yes ☐ no		Yes	No	Who
Alcohol: ☐ yes ☐ no	Asthma			
Tobacco/Smoking: ☐ yes ☐ no	Sickle Cell Disease			
Illnesses During Pregnancy: ☐ yes ☐ no	Cystic Fibrosis			
Meds During Pregnancy: ☐ yes ☐ no	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	Yes	No
Frequent Colds/Sore Throat	Yes	No	Chicken Pox: Year:	Yes	No	Seizures	Yes	No
Asthma/Bronchitis	Yes	No	Injuries i.e. broken bones/stitches	Yes	No	Stomach Problems	Yes	No
Tonsillitis	Yes	No	Blood Transfusion (s)	Yes	No	Heart Murmur	Yes	No
Allergies	Yes	No	Lead Poisoning	Yes	No	Diabetes	Yes	No
Bed wetting	Yes	No	Surgeries	Yes	No	Hospitalization	Yes	No
Last TB Screening Pos Neg Age Performed:								
Immunization up to date? ☐ YES ☐ NO ☐ DON'T KNOW								
Immunization Record Available Today? ☐ YES ☐ 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?	☐ 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
Frequents 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 Months	Holds head up		Smiles		Coos	
4-6 Months	Rolls over		Reach for objects		Laughs	
7-10 Months	Sits alone		Drinks from cup		Babbles	
11-15 Months	Walks		Scribbles		First words	
16-24 Months	Jump in place		Feeds self		Combines two words	
2-3 Years	Broad jump		Toilet trained		Uses sentences	
4-5 Years	Catches ball		Dresses self		Tells story	
6-8 Years	Jumps rope		Draws triangle		Reads words	
9-10 Years	Rides bicycle		Does household chores		Tells time	

Name, Telephone Number and Address of Previous Doctor: ______________________________

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Completed by: ______________________________ Date: ____________________

Doctor's Signature: ______________________________ Date: ____________________