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Cass County Pediatrics & Adolescents
An Affiliate of Children's Mercy

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NEW PATIENT QUESTIONNAIRE
Please fill out the appropriate sections.

NAME_____
DATE_____

Mother's name_____Age_____
Occupation_____
Father's name_____Age_____
Occupation_____
If adults in the household work outside the home, what child care arrangements are made?_____
_____

A. PREGNANCY AND BIRTH:

1.	Mother's age at birth	_____	
2.	Any illness during pregnancy	No	Yes
3.	Any medications other than vitamins	No	Yes
4.	Was the baby on time?	Yes	No
5.	Problems during labor & delivery?	No	Yes
6.	Problems after delivery?	No	Yes
7.	Any problems during the hospital stay?	No	Yes
	What kind?_____		
8.	Birth weight	_____	

B. PAST MEDICAL HISTORY:

1.	Where has your child gone for check-ups until now?	_____	
2.	Date of last check-up:	_____	
3.	Date of last dental check-up:	_____	
4.	Has your child had allergic reactions to any medications, foods, or insect bites?	No	Yes
	Which ones?_____		
5.	Has your child had reactions to any immunizations?	No	Yes
	Which ones?_____		
6.	Any hospitalizations other than for birth?	No	Yes
	For what?_____		
7.	Any serious injuries?	No	Yes
	What kind?_____		
8.	Are any medications taken regularly?	No	Yes
	Which ones?_____		
9.	Has your child had chicken pox?	No	Yes
	What age?_____		

C. FAMILY HISTORY:

1.	Are the child's parents both in good health?	Yes	No
2.	Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had: anemia, asthma, allergies,diabetes, high blood pressure, heart trouble, Tb, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, or list others._____		
	_____		
3.	List age, sex, and full name of brothers and sisters:_____		
	_____		
	_____		
4.	Have any of your children died?	No	Yes

D. FEEDING AND NUTRITION:

1.	Is your child's appetite usually good?	Yes	No
2.	Is it good now?	Yes	No
3.	Was there severe colic or any unusual feeding problems during the first 3 months?	No	Yes
4.	Do any foods disagree with him/her?	No	Yes
5.	For the first 6 months, is he/she (was he/she) breast fed or bottle fed?_____		
6.	If still on formula, which one do you use?_____		
7.	Does he/she take vitamins?	Yes	No

PLEASE GIVE US A COPY OF YOUR IMMUNIZATION RECORD.

E. REVIEW OF SYMPTOMS:

1.	Has your child had frequent ear infections?	No	Yes
2.	Any eye problems?	No	Yes
3.	Has he/she had any problems with teeth?	No	Yes
4.	Does he/she have frequent cold or sore throat?	No	Yes
5.	Is there asthma, pneumonia, or recurrent cough?	No	Yes
6.	Does he/she have a heart murmur or any heart problems?	No	Yes
7.	Any problems with urination?	No	Yes
8.	Any problems with diarrhea or constipation?	No	Yes
9.	Have there been any convulsions or other problems with the nervous system?	No	Yes
10.	Any eczema, hives, or other skin conditions?	No	Yes
11.	Has your child ever been anemic?	No	Yes
12.	Please list any other medical problems:_____		
	_____		
	_____		

F. DEVELOPMENT/BEHAVIOR:

1.	At what age did your child sit alone?	_____	
2.	At what age did he/she walk alone?	_____	
3.	Did he/she say any words by the time he/she was 11/2 years old?	Yes	No
4.	How does this child compare to others his/her age?	_____	
5.	Does he/she have any trouble sleeping?	No	Yes
6.	What grade is he/she in?	_____	
7.	Has he/she had any trouble in school?	No	Yes
8.	Does he/she get along with other children?	Yes	No
9.	Circle if your child has had any of the following: nail biting, thumb sucking, bed wetting, problems with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, any others:_____		

G. SAFETY/ENVIRONMENT:

1.	Do you live in a private house, apartment, mobile home, or other? (CIRCLE)		
2.	Do you know the hottest temperature of the water in your pipes?	Yes	No
3.	Is there a working smoke alarm on each floor in the house?	Yes	No
4.	Does your child always use a car seat/seat belt when riding in a car?	Yes	No
5.	Are there any smokers in the household, or in daycare?	No	Yes
6.	Are there any problems with the condition of your home? peeling paint, insects, rats, or mice?	No	Yes
7.	Does your child always wear a helmet when riding his/her bicycle?	Yes	No
8.	Do you have guns in the home? Are they locked away?	No / Yes	Yes / No

H. DO YOU HAVE ANY SPECIFIC CONCERNS?