Dr. Anne! Modern Parenting, Classic Healthcare.
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New Patient Questionnaire

Date / /

	Last Name	First Name	MI	
Patient				DOB / /
Mother				
Father				

Pregnancy and Birth

1	Mother's age at birth	_____	
2	Mother had illness during pregnancy?	N ☐	Y ☐
3	Mother took medications? (not vitamins)	N ☐	Y ☐
4	Baby born before due date? If Yes, how many weeks early? _____	N ☐	Y ☐
5	Baby birth weight		
6	Baby have trouble in hospital? if Yes, what kind of trouble? _____ _____ _____ _____	N ☐	Y ☐

Medical History

1	Child has allergies? (food, meds, insects)	N ☐	Y ☐
2	Child had reaction to vaccine?	N ☐	Y ☐
3	Child been to hospital? (not birth)	N ☐	Y ☐
4	Child had serious injury?	N ☐	Y ☐
5	Child had surgery?	N ☐	Y ☐
6	Child on regular medication?	N ☐	Y ☐

If Yes to any question above, explain.

_____

_____

_____

_____

7	Date of last checkup	_____/_____/_____
8	Date of last dental checkup	_____/_____/_____

Physician Notes

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Family History

1	Child's parents have health problems?	N ☐ Y ☐
2	Child's sibling, parent, grandparent, aunt/uncle had:	

- ☐ Asthma
- ☐ High blood pressure
- ☐ Inherited disease
- ☐ Allergies
- ☐ High cholesterol
- ☐ Sudden death
- ☐ Cancer
- ☐ Heart trouble
- ☐ Diabetes
- ☐ Tuberculosis

3	Have any of your children died?	N ☐ Y ☐

Social History

1 List household members and all siblings

Age	Sex	Relationship	Lives at home?	General Health
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________
______	M ☐ F ☐	__________	Y ☐	________________

2 List household pets

Kind of animal	Pet lives...		
________________	Inside ☐	Outside ☐	Inside & Outside ☐
________________	Inside ☐	Outside ☐	Inside & Outside ☐
________________	Inside ☐	Outside ☐	Inside & Outside ☐
________________	Inside ☐	Outside ☐	Inside & Outside ☐

3	Smokers in the child's home?	N ☐ Y ☐
4	Child attends daycare?	N ☐ Y ☐

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Feeding and Nutrition

1	Concerns with child's appetite?	N ☐	Y ☐
2	Colic or unusual feeding problem in first three months?	N ☐	Y ☐
3	During first 12 months, baby was: ☐ Breast fed ☐ Bottle fed ☐ Breast and bottle fed		

Review of Systems

1	Child had frequent ear infections?	N ☐	Y ☐
2	Child had eye problems?	N ☐	Y ☐
3	Child had teeth problems?	N ☐	Y ☐
4	Child has frequent colds or sore throat?	N ☐	Y ☐
5	Child had asthma, recurring cough, or pneumonia?	N ☐	Y ☐
6	Child has heart murmur or other heart trouble?	N ☐	Y ☐
7	Child has problems with urination?	N ☐	Y ☐
8	Child has problems with diarrhea or constipation?	N ☐	Y ☐
9	Child ever had convulsions or seizures?	N ☐	Y ☐
10	Child had eczema, hives, or other skin condition?	N ☐	Y ☐
11	Child has been anemic?	N ☐	Y ☐

Safety

1	Child lives in: ☐ Private house ☐ Apartment ☐ Mobile home ☐ Other		
2	Temperature of home hot water? _____ °F	☐ Don't know	
3	Home has working smoke alarm on each floor?	N ☐	Y ☐
4	Child always driven in car seat or using seatbelt?	N ☐	Y ☐
5	Child wears protective equipment for biking or skating?	N ☐	Y ☐

Note anything else you think relevant or important for Dr. Anne.

Physician Notes

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