# Yale Health Pediatric Department
## New Patient Questionnaire

**If possible attach a copy of your child's immunization record and return with this form at your appointment.**

| Child's Name | Date of Birth | Age |
|---|---|---|
| Address | Form Completed By | Date Completed |

| Home Phone | Cell Phone | Work Phone |
|---|---|---|
| | | |

**Household** - please list all those living in the child's home

| Name | Relationship to child | Age | Occupation | Health Problems |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

Are there siblings not listed? If so, please list their names and ages and where they live.

______________________________

______________________________

If parents are not living together or if child does not live with parents, what is the child's custody status?

______________________________

**Birth History**

Birth weight ______lbs. ________oz.
Was the baby born at term?____ Early? ____Late?____
If early, how many weeks gestation?__________
Did pregnant patient have any illness or problem with the pregnancy?
□ Yes □ No Explain ______________________________

______________________________
During pregnancy did patient: Smoke? □ Yes □ No
Drink alcohol? □ Yes □ No
Use drugs or medications? □ Yes □ No What? And When?
______________________________

Date of adoption (if applicable)____________
Was the delivery □ Vaginal? □ Cesarean?
If cesarean, why? ______________________________

______________________________
Did baby have any problems right after birth?□ Yes □ No
Explain______________________________

______________________________
Was initial feeding □ Breast? □ Bottle?
Did baby go home with patient from the hospital?
□ Yes □ No Explain______________________________

**General** (if applicable)

Do you consider your child to be in good health? □ Yes □ No Explain____________________
Does your child have any serious illness or medical condition? □ Yes □ No Explain____________________
Has your child had serious injuries or accidents? □ Yes □ No Explain____________________
Has your child had any surgery? □ Yes □ No Explain____________________
Has your child been hospitalized? □ Yes □ No Explain____________________
Does your child have any allergies? □ Yes □ No Explain____________________
Does your child take any medications on a regular basis? □ Yes □ No Explain____________________

**Development** (if applicable)

Name of school (or daycare) and grade in school______________________________
How is his/her/their behavior in school? ______________________________
Has he/she/they repeated a grade in school? ______________________________
How is he/she/they doing in academic subjects? ______________________________
Is he/she/they in special or resource classes? ______________________________

Are you concerned about your child's physical development? □ Yes □ No Explain____________________
Are you concerned about your child's mental or emotional development? □ Yes □ No Explain____________________
Are you concerned about your child's attention span? □ Yes □ No Explain____________________

Clinician Signature______________________________

**OVER--->**

| Child's Name | Date of Birth |
|---|---|
| | |

**Family History –** have any family members had the following: ☐ Unknown

| | | | | |
|---|---|---|---|---|
| Deafness | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Allergies (food or environmental) | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Asthma | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Tuberculosis | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Heart disease or sudden death (before 50 years old) | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| High blood pressure (before 50 years old) | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| High cholesterol | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Anemia/Bleeding disorder | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Liver/Kidney disease | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Diabetes (before 50 years old) | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Epilepsy or convulsions | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Alcohol/Drug abuse | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Mental illness/depression | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Mental retardation | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Immune problems, HIV or AIDS | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Cancer | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |
| Gastrointestinal problems | ☐ Yes | ☐ No | Who______________ | Comments______________________________ |

**Past History** (if applicable) – Does your child have or has he/she/they ever had:

| | | | |
|---|---|---|---|
| Chickenpox | ☐ Yes | ☐ No | When______________________________________ |
| Frequent ear infections/hearing loss | ☐ Yes | ☐ No | Explain______________________________________ |
| Allergies (food or environmental) | ☐ Yes | ☐ No | Explain______________________________________ |
| Problems with eyes or vision | ☐ Yes | ☐ No | Explain______________________________________ |
| Asthma, bronchitis, bronchiolitis or pneumonia | ☐ Yes | ☐ No | Explain______________________________________ |
| Any heart problem or heart murmur | ☐ Yes | ☐ No | Explain______________________________________ |
| Anemia or bleeding problem | ☐ Yes | ☐ No | Explain______________________________________ |
| Frequent abdominal pain/constipation | ☐ Yes | ☐ No | Explain______________________________________ |
| Bladder or kidney infection | ☐ Yes | ☐ No | Explain______________________________________ |
| Bed-wetting (after 5 years old) | ☐ Yes | ☐ No | Explain______________________________________ |
| Has your child started a menstrual period | ☐ Yes | ☐ No | When and list any problems__________________________ |
| Any chronic or recurrent skin problem | ☐ Yes | ☐ No | Explain______________________________________ |
| Frequent headaches | ☐ Yes | ☐ No | Explain______________________________________ |
| Convulsions or other neurological problems | ☐ Yes | ☐ No | Explain______________________________________ |
| Diabetes | ☐ Yes | ☐ No | Explain______________________________________ |
| Thyroid or other endocrine problems | ☐ Yes | ☐ No | Explain______________________________________ |
| Alcohol/Drug use | ☐ Yes | ☐ No | Explain______________________________________ |
| Any other significant problems | ☐ Yes | ☐ No | Explain______________________________________ |

**Home Environment –** Please check all that are in the household where the child resides:

| | | |
|---|---|---|
| ☐ Smokers | ☐ Smoke detectors | ☐ Pets________________ (type) |
| ☐ Guns/Firearms | ☐ Carbon monoxide detectors | |