# Mountain View Pediatrics

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## *NEW PATIENT QUESTIONAIRE*

**Child's Name:**_____ **Date of Birth:**_____/_____/_____ **Date:**____/_____/**2014**

**Race:**_____ **Gender:**_____ **Ethnicity:**_____ **Preferred Language:**_____

**Child's Previous Doctor & Address:**_____

**Allergies/Reactions to Medicines or Vaccines:**_____

**Current Medications:**_____

***PREGNANCY AND BIRTH:***

Any problems with the pregnancy? □ Y □ N Any illness during pregnancy? □ Y □ N
Was the baby born on time? □ Y □ N Delivered: □ Vaginal □Cesarean Birth Weight:_____
Did the baby have any problems is the hospital? □ Y □ N _____

***PAST MEDICAL HISTORY:***

Hospitalizations □ Y □ N When/Why?:_____
Surgeries □ Y □ N When/Why?:_____
Any serious injuries:_____
Does your child have any of the following conditions? (Check all that apply)
□Asthma □Eczema □Hay Fever □Attention Problems □Croup □Anemia □ Problems Going Potty
□Frequent Ear Infections □Pneumonia □RSV □Chicken Pox □Urine Infection □Wheezing

Immunizations: □ Up to Date □Behind □ I Don't Know

***FAMILY HISTORY:*** (Check any problems that this child's parents, brothers, sisters, aunts or uncles ever had)
□Anemia □Asthma □Allergies □Diabetes □Tuberculosis □Heart Trouble □High Blood Pressure
□Mental Illness □Drug Problems □Alcohol Problems □Inherited Problems □Cancer □HIV/AIDS
□ Bleeding Problems □Seizures □Thyroid Problems Other:_____

***SOCIAL HISTORY:***

Who lives at home? (Use back of page if needed)

| NAME | AGE | RELATIONSHIP | GENERAL HEALTH |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

School/Daycare:_____ Days per week/Grade:_____
Home Safety: □Seat belt/Car seat □Bike helmet □Smoke detectors □Guns □Smokers □Pets □Swimming pool

***DEVELOPMENT:***

At what age did your child:

Walk Alone? _____ Said First Word? _____
Sit Alone? _____ Had First Tooth? _____