NORTHERN NEVADA PEDIATRICS
INITIAL PATIENT QUESTIONNAIRE

Please complete this confidential questionnaire so we can better care for your child.

CHILD'S NAME: _____ DATE OF BIRTH _____

PERSON COMPLETING QUESTIONNAIRE: _____

HOUSEHOLD Please list those living in the child's home.

NAME	DATE OF BIRTH	RELATIONSHIP TO CHILD	HEALTH PROBLEMS

What is child's living situation if not with both biological parents? (Check one)
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody ☐ Lives with foster family
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
_____

BIRTH HISTORY
Birth weight _____ was the baby born at term or premature ? _____ weeks
Was the delivery (check one) ☐ Vaginal? ☐ Cesarean? If cesarean, why?_____
Any problems during pregnancy? ☐ YES ☐ NO
If YES, please describe: _____
Was mom on any medications during the pregnancy? ☐ YES ☐ NO
If YES, please describe: _____
Cigarettes/alcohol/drug use during the pregnancy? ☐ YES ☐ NO
If YES, please describe: _____
Any complications with the baby? ☐ YES ☐ NO
If YES, please explain:_____

GENERAL
Where has your child gone for check-ups until now? _____
Date of last check-up: _____
Do you consider your child to be in good health? ☐ YES ☐ NO
If NO, please explain:_____

Has your child had/have any of the following:
Allergic reaction to food or medications? ☐ YES ☐ NO
If YES, please explain: _____
Hospitalizations? ☐ YES ☐ NO
If YES, please explain: _____
Surgery ? ☐ YES ☐ NO
If YES, please explain: _____
Dental visit? ☐ YES ☐ NO
If YES, date of last visit: _____

CHILD'S PAST HISTORY

Does your child have or has your child ever had: (check)

☐ Chickenpox (year____) ☐ Frequent ear infections ☐ Hearing problems ☐ Nasal allergies
☐ Problems with eyes/vision ☐ Asthma ☐ Bronchitis ☐ Pneumonia ☐ Heart problem
☐ Blood transfusion ☐ Frequent abdominal pain ☐ Constipation requiring Dr. visits
☐ Urinary tract infection ☐ Kidney disease or urologic malformations
☐ Metabolic/Genetic disorders ☐ Cancer ☐ Sleep problems ☐ Persistent snoring
☐ Chronic or recurrent skin problems ☐ Frequent headaches ☐ Obesity ☐ Dental decay
☐ Convulsions or other neurological problems ☐ Diabetes ☐ Thyroid or other endocrine problems
☐ High blood pressure ☐ History of serious injuries/fractures/concussions
☐ Use of alcohol/drugs ☐ ADHD/anxiety/mood problems/depression ☐ Anemia
☐ (For girls) Problems with periods? Has had first period? ☐ YES ☐ NO Age at first period:_____
☐ Any other significant problem? _____
☐ None of the above

DEVELOPMENT/SCHOOL CONCERNS

Have you ever had any concerns regarding your child's: (please check your response)

☐ Slow development (sitting, walking, talking) ☐ Speech (late talker, hard to understand)
☐ School difficulties (learning, attention) ☐ Other concerns:_____

BIOLOGICAL FAMILY HISTORY

Have any family members had the following?

Childhood hearing loss	☐ YES	☐ NO	WHO?_____
Nasal allergies	☐ YES	☐ NO	WHO? _____
Asthma	☐ YES	☐ NO	WHO? _____
Tuberculosis	☐ YES	☐ NO	WHO? _____
Heart disease (before 55 years old)	☐ YES	☐ NO	WHO? _____
High cholesterol/takes medication	☐ YES	☐ NO	WHO? _____
Anemia	☐ YES	☐ NO	WHO? _____
Bleeding disorder	☐ YES	☐ NO	WHO?_____
Dental decay	☐ YES	☐ NO	WHO? _____
Cancer (before 55 years old)	☐ YES	☐ NO	WHO? _____
Liver disease	☐ YES	☐ NO	WHO? _____
Kidney disease	☐ YES	☐ NO	WHO? _____
Diabetes (before 55 years old)	☐ YES	☐ NO	WHO? _____
Bed-wetting (after 10 years old)	☐ YES	☐ NO	WHO? _____
Obesity	☐ YES	☐ NO	WHO? _____
Epilepsy or convulsions	☐ YES	☐ NO	WHO? _____
Alcohol / Drug abuse	☐ YES	☐ NO	WHO? _____
Mental illness/depression	☐ YES	☐ NO	WHO? _____
Developmental disability	☐ YES	☐ NO	WHO? _____
Immune problems, HIV or AIDS	☐ YES	☐ NO	WHO? _____
Tobacco use	☐ YES	☐ NO	WHO? _____

Additional family history: _____

Please check any stresses in your household or environment:

☐ Job difficulties ☐ Separation/divorce ☐ Domestic violence ☐ Mental illness
☐ Drug/alcohol abuse ☐ Incarceration ☐ Other: _____
_____