TEXAS GULF COAST
medical systems

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Print Form

PEDIATRIC NEW PATIENT QUESTIONNAIRE 4 OR YOUNGER

Fillable Form

NOTE: This form can be filled out from your screen. Just click in the open space beside each query and type in the requested info.

You can click "Highlight Fields" in the top right corner of your PDF Reader to view all the fillable areas. Click the 'email' and/or 'print' button(s) above when finished.

Name:	Date of Birth: Day Month Year	Today's Date: Day Month Year

Dear Patients: Please complete as much of this form as you can.
It will help us learn more about your child and help us give him/her a better examination

Current Information

What is the reason for today's visit?

Is your child now taking any medications? ☐ Yes ☐ No If yes, which?

List any medications to you which your child may be allergic and describe the reaction:

Does your child have any severe reaction to foods or insect bites?

Past History

Pregnancy and Birth (this child)

Age of mother at time of birth:	Living children:	Miscarriages or stillbirths:	This was pregnancy number:

The Pregnancy was: ☐ 9 months ☐ premature ☐ prolonged

Was the pregnancy complicated by: ☐ anemia ☐ bleeding ☐ high blood pressure ☐ illness or infection
☐ diabetes ☐ need for any medication ☐ other

Where was this child born?	Birth weight:

Was the delivery: ☐ breech delivery ☐ Caesarean section ☐ forceps delivery
☐ under general anasthesia ☐ difficult or prolonged ☐ other

Feeding History (input a number where it asks for months)

Breast fed months	Formula fed months	Name of formula:

Solid food began at months	Table food at months	Does your child eat well? ☐ Yes ☐ No

What foods, if any, can your child not eat?

What vitamins, if any, do you give your child?

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Growth and Development

Cities in which child has lived:	Do parents/caretakers smoke? ☐ Yes ☐ No
Are there pets in the home/yard? ☐ Yes ☐ No	Does patient eat dirt, paint or other non-food items? ☐ Yes ☐ No

Please list and describe any hospitalizations, operations, injuries or serious illnesses and the year or age they occurred:

Immunizations

Is your child up to date? ☐ Yes ☐ No (Please provide us with a copy of the immunizations.)

Family History	Name	Age / Height / Weight	Condition of Health	Occupation
Mother:		Lbs.		
Father:		Lbs.		
Siblings:		Lbs.		
		Lbs.		
		Lbs.		
		Lbs.		

Please state relationships of immediate or extended family members who have the following problems:

Allergies:		Asthma:
Blood disorders (including Sickle Cell):		Birth defects:
Bleeding problems:		Convulsions or epilepsy:
Cystic Fibrosis:		Diabetes (adult or childhood):
Heart disease in adults under 55 years:	Heart Attacks	Hardening of arteries
Heaty bypass	Strokes	Angina
Heart disease in children:		High cholesterol (over 240 or on medication):
Mental retardation:		Migraine headaches:
Thyroid disease:		Tuberculosis:
Other:		

Does your child have a history of the following problems? (Now or in the past)

- ☐ Allergy, hay fever or sinus problems
- ☐ Asthma, wheezing or shortness of breath
- ☐ Bronchitis or pneumonia
- ☐ Chronic cough
- ☐ Frequent ear infections
- ☐ (How many? _____ Needed PE tubes? ☐ Yes ☐ No)
- ☐ Frequent throat infections, tonsillitis, or colds
- ☐ Hearing problems
- ☐ Heart murmur or other heart problems
- ☐ Convulsion, febrile seizure or staring spells
- ☐ Head injury or concussion
- ☐ Unusual clumsiness
- ☐ Eating problems
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Growth problems or weight loss
- ☐ Abdominal pain, chronic
- ☐ Bloody or tarry stools
- ☐ Constipation of diarrhea
- ☐ Vomiting or nausea, chronic
- ☐ Anemia
- ☐ Easy bleeding or bruising
- ☐ Sickle cell trait or disease
- ☐ Chickenpox
- ☐ Measles
- ☐ Exposure to tuberculosis
- ☐ Frequent unexplained fever
- ☐ Deformity or swelling of limbs
- ☐ Urinary tract or bladder infections
- ☐ Frequent or painful urination
- ☐ Eczema or other skin problems

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