



TEXAS GULF COAST
medical systems

**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:	Day Date of Birth:	Month	Year	Day Today's Date:	Month	Year
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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:
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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 anesthesia difficult or prolonged other

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

Breast fed months	Formula fed months	Name of formula:
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Solid food began at months	Table food at months	Does your child eat well? Yes No
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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	
Heart 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 or 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