TEXAS GULF COAST
medical systems

PHONE: (281) 604-1300 FAX: (281) 724-0355

Print Form

PEDIATRIC NEW PATIENT QUESTIONNAIRE 5 OR OLDER

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

List any major problems with pregnancy, delivery, newborn period

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

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:

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

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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 throat infections, tonsillitis, or colds
- ☐ Hearing problems
- ☐ Heart murmur or other heart problems
- ☐ Frequent Chest Pain
- ☐ Convulsions or staring spells
- ☐ Dizziness of fainting
- ☐ Frequent headaches
- ☐ Head injury or concussion
- ☐ Unusual clumsiness
- ☐ Vision problems
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Growth problems or weight loss
- ☐ Abdominal pain, chronic
- ☐ Bloody or tarry stools
- ☐ Constipation or diarrhea
- ☐ Soiling pants
- ☐ Vomiting or nausea, chronic
- ☐ Anemia
- ☐ Easy bleeding or bruising
- ☐ Sickle cell trait or disease
- ☐ Chickenpox
- ☐ Mononucleosis
- ☐ Measles
- ☐ Exposure to tuberculosis
- ☐ Frequent unexplained fever
- ☐ Deformities
- ☐ Joint swelling or pain
- ☐ Urinary tract or bladder infections
- ☐ Frequent or painful urination
- ☐ Bedwetting or daytime wetting
- ☐ Menstrual irregularity or abnormality
- ☐ Eczema or other skin problems
- ☐ Behavior problems
- ☐ School problems
- ☐ Easily saddened or depressed
- ☐ Mood swings
- ☐ Change in appetite or sleep habits