



NEW PATIENT QUESTIONNAIRE FOR NEWBORN TO SIX MONTHS
TO BE FILLED OUT BY PARENT

Child's Name _____ Date _____
Mother's Name _____ Age _____
Occupation _____
Father's Name _____ Age _____
Occupation _____
If adults in the household work outside the home, what child care arrangements are made for this child? _____

PREGNANCY AND BIRTH

1. Was the baby on time? Yes No
2. What was the birth weight? _____
3. Did mother have any illness during pregnancy? Yes No
4. Did she take any medications other than vitamins and iron? Yes No
5. Did the baby have any trouble starting to breathe? Yes No
6. Did the baby have any trouble while in the hospital?
(jaundice, infections, other?) What Kind? _____
7. List any medical problems your child has _____

FAMILY HISTORY

1. Are the child's parents both in good health? Yes No
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had:
asthma diabetes heart trouble inherited illness cancer Anxiety ADHD
allergies high blood pressure substance abuse mental illness AIDS Depression other _____
3. List age, sex, and general health of brothers and sisters _____
4. Have any of your children died? Yes No

FEEDING AND NUTRITION

1. Is your child breastfed? Yes No
2. Is your child formula fed? Yes No
If yes, which one do you use? _____
3. Does he/she take vitamins? Yes No

Do you have a record of immunizations? Yes No

How did you hear about our office? _____
Are you new to the area? Yes No
If yes, circle one: Walker Wyoming