Jercinovic Pediatrics

NEW PATIENT MEDICAL QUESTIONNAIRE

All information must be filled out in full

PLEASE PRINT

Today's Date:					
Patient's Last Name:	First:	Middle:		Date of Birth:	Sex: □M □F
Street Address:	City:	State:	Zip:	Home Phone: Other Emergency #:	
Mother's Cell Phone:	Mother's work #	Father's Cell Phone:	Father's work #	Other Contact numbers:	
Does the child go by any other name?					

PREGNANCY AND BIRTH					
Birth City:	State:	Birth Hospital:	Birth Weight:	Was it a regular or Cesarean delivery?	Mother's age at birth:
Was the baby on time? □ Yes □ No	If not on time, how much early/late?		Did baby have trouble breathing? □ Yes □ No		Please state APGAR score if you know
Did baby have any health problem while in hospital? (Jaundice, infections, other)	If yes, please explain.				
Did mother have any illness during pregnancy? □ Yes □ No	If yes, please explain.				
Did mother take any medications/drugs during pregnancy?	□ Yes □ No	If yes, please explain.			

PAST MEDICAL HISTORY		
Has your child had allergic reactions to any medications, foods, insect bites? □Yes □ No	If yes, please explain.	
Has your child had any unfavorable reactions to immunizations? □Yes □ No	If yes, please explain.	
Any hospitalizations, serious injuries or surgery? □Yes □ No	If yes, please explain.	
Has your child ever been diagnosed with any chronic/ongoing illness? (Asthma, Diabetes, Heart condition, ADHD, or other? □Yes □ No	If yes, please explain.	
Does your child take any medications on regular basis? □Yes □ No	If yes, please explain.	
When was your child's last check-up?	Date:	Physician's name:
When was your child's last dental check-up?	Date:	Dentist's name:
Are your child's immunizations up to date?	□Yes □ No	

DEVELOPMENT/BEHAVIOR	
At what age did your child sit alone? _____ walk alone? _____start talking 10 words? _____start talking short sentences? _____	
Does your child have trouble sleeping? □Yes □ No	Does your child have trouble at school? □Yes □ No
Does your child have trouble learning? □Yes □ No	Any behavioral problems? □Yes □ No
What grade is he/she in? ___	Does he/she get along with other children? □Yes □ No
Circle if your child has had any of the following:	Thumb sucking, bad temper, hyperactivity, nightmares, speech problem, discipline problem, … others?

FEEDING AND NUTRITION	
Is your child's appetite usually good? □Yes □ No	Is it good now? □Yes □ No
Do any foods disagree with him/her? □Yes □ No	Does he/she take vitamins? □Yes □ No
Was there severe colic or unusual feeding problem in first 3 months of age?	□Yes □ No
Was the baby breast or bottle fed? _____ For how long _____	If still on formula … which one?

FAMILY HISTORY			
Are the child's parents both in good health? □Yes □ No			
Circle any disease that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had:		Anemia, asthma, allergies, diabetes, AIDS, high blood pressure, heart trouble, tuberculosis, mental illness, drug problem, alcohol problem, inherited illness, venereal disease, cancer, others:	
List name, age, sex, and health of brothers and sisters.			
Name:	Sex: M F Age:	Health:	
Name:	Sex: M F Age:	Health:	
Name:	Sex: M F Age:	Health:	
Name:	Sex: M F Age:	Health:	
Name:	Sex: M F Age:	Health:	
Have any of your children died? □Yes □ No			
Who are the people that live in the household?			
Do both parents live in the household? □Yes □ No		If not, are they separated/divorced?	

REVIEW OF SYSTEMS			
Has your child had frequent ear infections?	□Yes □ No	Eye problems?	□Yes □ No
Does he/she have frequent colds?	□Yes □ No	Any problems with kidneys or urination?	□Yes □ No
Any history of heart problems, or murmur?	□Yes □ No	Any history of asthma, pneumonia, bronchitis?	□Yes □ No
Any problems with diarrhea or constipation?	□Yes □ No	Any history of seizures, convulsions?	□Yes □ No
Any other problems with nervous system?	□Yes □ No	Any behavioral issues?	□Yes □ No
Any history of hives, eczema or other skin issues?	□Yes □ No	Has your child ever been anemic?	□Yes □ No
Please list any other medical problems or comments.			

SAFETY/ENVIROMENT		
Do you live in a private house, apartment, mobile home, other? (please circle)		
Do you know the hottest temperature in your home water pipes?	□Yes □ No	
Is there a working smoke alarm on each floor of the house?	□Yes □ No	
Are there any problems with the condition of the home?	□Yes □ No	Peeling paint, insects, rats, very humid, mold (Circle if any apply)
Are there smokers in the house?	□Yes □ No	
Does your child wear a helmet while riding his/her bicycle?	□Yes □ No	

USE THIS AREA IF YOU NEED MORE ROOM TO COMMENT ON ANY QUESTION