St. Charles Family Medicine Center, S.C.

NEW PATIENT PEDIATRIC QUESTIONNAIRE

Date: _____

Name: _____ Birth date: _____

MEDICAL HISTORY

1. Place of birth: _____

2. List any significant problems with pregnancy, labor of delivery or in the 1st few months of life: _____

3. List any significant health problems since: _____

4. Known allergies: (include foods, pollens, medicines) and type of reaction (ie. hives, rash, vomiting): _____

5. Serious chronic illness or health problems: _____

6. Surgeries/Procedures: _____

7. Medications: _____

8. Hospitalizations other than birth: _____

9. Accidents/Injuries: _____

10. Other physicians seen regularly: _____

11. Are immunizations up to date? _____ Yes _____ No

12. Has your child been screened for any developmental problems? ____ Yes ____ No
If yes, please describe: _____

13. Has mom had any postpartum depression since having this baby? ____ Yes ____ No
If yes, please explain: _____

SOCIAL HISTORY

1. Please list the name, age and relationship for all persons currently living in your home:

_____

_____

_____

2. Does your child attend daycare? _____ Yes _____ No
   If yes, or you plan to, what is it's name and # of days per week attended? _____

_____

3. Parental Occupations:

Mother: _____

Father: _____

4. Is your home or apartment more than 30 years old? _____ Yes _____ No
   If yes, has the patient been tested for lead? _____ Yes _____ No

5. Has your house been tested for radon? _____ Yes _____ No

6. Does your house have its own well? _____ Yes _____ No

7. Is your home child proofed? _____ Yes _____ No

8. Is anyone immunocompromised in your household (ie. cancer, HIV, etc)?
____ Yes ____ No

9. Does anyone in your family use any of the following: _____ Yes _____ No

	Child	Family member	How often?
Cigarettes	_____	_____	_____
Alcohol	_____	_____	_____
Drugs	_____	_____	_____

10. Any recent family changes? _____ Yes _____ No If yes, please explain:

_____

Any other information we should know about, but have not asked?

_____

_____

_____

_____