CAROLINAEAST PEDIATRICS

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NEW PATIENT QUESTIONNAIRE

Patient Name:_____

Date:_____

MRN:_____

Mother's Name:_____

Mother's Occupation:_____

Father's Name:_____

Father's Occupation:_____

Other primary caretakers (foster care, grandparents, etc):_____

Plan for childcare if adults are working outside the home:_____

PREGNANCY AND BIRTH

1. Did mother have any illnesses during pregnancy? ☐ No ☐ Yes
2. Did she take any medications during pregnancy? ☐ No ☐ Yes
3. Did mother use tobacco during pregnancy? ☐ No ☐ Yes
4. Did mother use alcohol during pregnancy? ☐ No ☐ Yes
5. Did mother use any other illicit drugs during pregnancy? ☐ No ☐ Yes
6. How many weeks was the baby at birth? _____
7. ☐ Vaginal Delivery ☐ C-section
8. What was the baby's birth weight? _____
9. Did the baby have problems in the nursery (breathing, jaundice, infections, other?) ☐ No ☐ Yes
10. If boy baby - was your baby circumcised as an infant? ☐ No ☐ Yes

PAST MEDICAL HISTORY

1. Has your child had any allergic reactions to medications, foods, insects, etc? ☐ No ☐ Yes
2. Has your child had any reactions to vaccines? ☐ No ☐ Yes
3. Has your child had any hospitalizations other than birth? ☐ No ☐ Yes
4. Has your child ever had surgery? ☐ No ☐ Yes
5. Does your child see any special doctors (heart doctor, eye doctor, etc)? ☐ No ☐ Yes
6. Does your child always use a car seat or seatbelt when riding in the car? ☐ No ☐ Yes
7. Are there any smokers in the home (even if smokes outside, please answer yes) ☐ No ☐ Yes
8. Are there any guns in the home? ☐ No ☐ Yes
9. Do you have a record of their immunizations? ☐ No ☐ Yes
10. What is the living situation if not living with birth mother?

Is there anything else you think is important for your child's doctor to know?

FAMILY MEDICAL HISTORY

Please include patient's siblings, parents, and grandparents.
If "yes" answer to any of the following questions, please include which family member and any other pertinent information.

1. Inherited illnesses ☐ No ☐ Yes
2. Immune problems (other than HIV/AIDS) ☐ No ☐ Yes
3. Diabetes (type 1/childhood) ☐ No ☐ Yes
4. Diabetes before age 50 (type 2/adult) ☐ No ☐ Yes
5. Sudden death before age 50 ☐ No ☐ Yes
6. Deafness ☐ No ☐ Yes
7. Nasal allergies ☐ No ☐ Yes
8. Asthma ☐ No ☐ Yes
9. Heart disease (before age 50) ☐ No ☐ Yes
10. High blood pressure (before age 50) ☐ No ☐ Yes
11. High cholesterol ☐ No ☐ Yes
12. Anemia ☐ No ☐ Yes
13. Bleeding disorder ☐ No ☐ Yes
14. Liver disease ☐ No ☐ Yes
15. Kidney disease ☐ No ☐ Yes
16. Bed-wetting (after age 10) ☐ No ☐ Yes
17. Epilepsy/seizures/convulsions ☐ No ☐ Yes
18. Alcohol abuse ☐ No ☐ Yes
19. Drug abuse ☐ No ☐ Yes
20. Anxiety/Depression ☐ No ☐ Yes
21. Mental illness ☐ No ☐ Yes
22. Mental retardation ☐ No ☐ Yes
23. HIV/AIDS ☐ No ☐ Yes
24. Thyroid problems ☐ No ☐ Yes
25. Cancer (which types if yes) ☐ No ☐ Yes
26. Additional family history?

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 252-636-1919.
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 252-636-1919.