New West PHYSICIANS

Part of Optum®

PEDIATRIC HEALTH QUESTIONNAIRE

Child's Last Name: _____ First Name: _____ DOB: _____ Age: _____
Parent/Guardian Name(s): _____
Previous Physician: _____
Medicines/Vitamins: _____
Allergies/Adverse Reactions: _____

Please make sure we have your **child's immunization record.** Bring a copy to your child's next visit or fill out a release form in the office today so that New West Physicians can obtain it from your child's previous health care provider(s).

PREGNANCY & BIRTH

Place of birth: _____
Delivery by ☐ Vaginal ☐ Cesarean
If Cesarean, why? _____
Birth weight: _____ Birth length: _____
Was child premature? ☐ Yes ☐ No
If so, how early? _____
Was child adopted? _____

DENTAL/EYE HISTORY

Has child seen a Dentist? ☐ Yes ☐ No
Date of last visit: _____
How often? _____
Has child seen an eye doctor? ☐ Yes ☐ No
Date of last visit: _____
Does child have glasses or contacts? ☐ Yes ☐ No

EXPOSURE/HABITS

Does your child live in or regularly visit a house built before 1950? ☐ Yes ☐ No
Do any household members smoke? ☐ Yes ☐ No
TV – hours per day _____
Computer – hours per day _____
Video games – hours per day _____

SCHOOL HISTORY

Does your child attend school/preschool?
☐ Yes ☐ No
Current grade: _____ School: _____
Any concerns about school performance?

_____

Any concerns about relationship with:
Teachers ☐ Yes ☐ No
Peers ☐ Yes ☐ No
Sports/exercise: Type? _____
How often? _____

HEALTH HISTORY

If your child has every had any of these problems, please write the age at which the problem occurred or started.

_____ Asthma
_____ Acne
_____ Bed-wetting
_____ Behavior problems or behavioral disorder
_____ Bladder / kidney infection
_____ Broken bones
_____ Chicken pox
_____ Concussion
_____ Depression / anxiety
_____ Developmental delays
_____ Diabetes
_____ Eye or vision problems
_____ Emotional problems
_____ Frequent ear infection
_____ Genetic disorder
_____ Hearing problems
_____ Frequent headaches
_____ Heart problems or murmur
_____ Learning problems
_____ Overweight / obesity
_____ Scoliosis
_____ Seizures
_____ Skin problems
_____ Sleep problems
_____ Speech problems
_____ Recurrent stomach pains
_____ Thyroid problems
_____ Other: _____

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Child's Name: _____

Date of Birth: _____

HEALTH HISTORY CONT.

Has your child ever been hospitalized or had surgery?

If yes, please explain (What for? When?)

Does your child see any specialists? If so, please list each doctor's name and what your child sees him/her for.

Any worries about your child's growth or development compared with his or her peers?

SOCIAL HISTORY

Who does your child live with? Please include the ages of other children in the household(s). If there are custody arrangements, please describe.

Is there anything you would like to discuss during your child's visit today?

FAMILY HISTORY

Please indicate any deaths of the child's immediate family members:

Please indicate family members (child's parent, sibling, grandparent, aunt, or uncle) with any of the following conditions:

Abbreviations for relatives:

M = mother
F = father
S = sister
B = brother
MGM = maternal grandmother (mother's mother)
MGF = maternal grandfather (mother's father)
PGM = paternal grandmother (father's mother)
PGF = paternal grandfather (father's father)
MA = maternal aunt (mother's sister)
MU = maternal uncle (mother's brother)
PA = paternal aunt (father's sister)
PU = paternal uncle (father's brother)

YES	WHO?	CONDITION	YES	WHO?	CONDITION
		Heart attack			Anemia
		High blood pressure			Cancer: what type?
		High cholesterol			Anxiety/depression
		Stroke			Epilepsy/seizures
		Asthma			Glaucoma
		Tuberculosis			Alcoholism/other addiction
		Liver disease			Diabetes
		Kidney disease			Thyroid
		Developmental delay/mental retardation			Genetic Disorder (specify):
		Other:			Other: