Physicians at Sweetwater
16659 SW Freeway, Suite 301
Sugar Land, TX 77479

PEDIATRIC NEW PATIENT QUESTIONNAIRE
5 OR OLDER

Name: ____________________ Date of Birth: ____________________
Today's Date: ____________________

Dear Patients: Please complete as much of this form as you can. It will help us learn more about your child and help us to give him/her a better examination.

Current Information

What is the reason for today's visit? ____________________

Is your child now taking any medications? ____________________
List any medications to which your child may be allergic and describe the reaction: ____________________

Does your child have any severe reaction to foods or insect bites? ____________________

Past History

List any major problems with pregnancy, delivery, newborn period: ____________________

Are your child's immunizations up to date? ❒ Yes ❒ No (Please provide us with a copy.)
Cities in which child has lived: ____________________
Do parents or caretakers smoke? ❒ Yes ❒ No Age at first menstrual period: ____________________
Are there pets in the home/yard? ____________________
Does patient eat dirt, paint or other nonfood items? ____________________
Please list any hospitalizations, operations, injuries, or serious illnesses and the year or age they occurred.

Family History

	Name	Age/Height/Weight	Condition of Health	Occupation
Mother				
Father				
Siblings				

Please list relationships of immediate or extended family members who have the following problems.

Allergies: ____________________
Asthma: ____________________
Blood disorders, including Sickle Cell: ____________________
Birth defects: ____________________
Bleeding problems: ____________________
Convulsions or epilepsy: ____________________
Cystic Fibrosis: ____________________
Diabetes (adult or childhood): ____________________
Heart disease in children: ____________________
Heart disease in adults under 55 years:
- Heart attacks: ____________________ Hardening of the arteries : ____________________
- Strokes: ____________________ Heart bypass: ____________________
- Angina: ____________________

High cholesterol (over 240 or on medication): ____________________
High blood pressure: ____________________
Mental retardation: ____________________
Migrane headaches: ____________________
Thyroid disease: ____________________
Tuberculosis: ____________________
Other: ____________________

Does your child have a history of the following problems? (Now or in the past)

- ❒ Allergy, hay fever, or sinus problems
- ❒ Asthma, wheezing, or shortness of breath
- ❒ Bronchitis or pneumonia
- ❒ Chronic cough
- ❒ Frequent throat infections, tonsillitis, or colds
- ❒ Hearing problems
- ❒ Heart murmur or other problems
- ❒ Frequent chest pain
- ❒ Convulsions or staring spells
- ❒ Dizziness of fainting
- ❒ Frequent headaches
- ❒ Head injury or concussion
- ❒ Unusual clumsiness
- ❒ Vision problems
- ❒ Excessive sweating
- ❒ Excessive thirst
- ❒ Growth problems or weight loss
- ❒ Abdominal pain, chronic
- ❒ Bloody or tarry stools
- ❒ Constipation or diarrhea
- ❒ Soiling pants
- ❒ Vomiting or nausea, chronic
- ❒ Anemia
- ❒ Easy bleeding or bruising
- ❒ Sickle cell trait or disease
- ❒ Chickenpox
- ❒ Mononucleosis
- ❒ Measles
- ❒ Exposure to tuberculosis
- ❒ Frequent unexplained fever
- ❒ Deformities
- ❒ Joint swelling or pain
- ❒ Urinary tract or bladder infections
- ❒ Frequent or painful urination
- ❒ Bedwetting or daytime wetting
- ❒ Menstrual irregularity or abnormality
- ❒ Eczema or other skin problems
- ❒ Grade in school __________ Usual grades ___________
- ❒ Behavior problems
- ❒ School problems
- ❒ Easily saddened or depressed
- ❒ Mood swings
- ❒ Change in appetite or sleep habits