NEW PATIENT QUESTIONAIRE
TO BE FILLED OUT BY PARENT

EAST BAY PEDIATRIC PRIMARY CARE, INC.
2324 Santa Rita Road, Suite 12, Pleasanton, CA 94566
(925) 462-7700

Mother's Name ________________________________ Age ____________

NAME __________________________

Occupation ____

DATE __________________________

Father's Name ________________________________ Age ____________

Occupation ____
If adults in the household work outside the home, what child care arrangements are made for this child? ____________________________________

A. PREGNANCY AND BIRTH:
1. Mother's age at birth ___________
2. Did mother have an illness during pregnancy? No Yes
3. Did she take any medications other than vitamin and iron? No Yes
4. Was the baby on time? No Yes
5. What was the birth weight? ___________
6. Did the baby have any trouble starting to breathe? No Yes
7. Did the baby have any trouble while in the hospital? No Yes
   (jaundice, infections, other?)
   What kind? ____
   ____

B. PAST MEDICAL HISTORY:
1. Where has your child gone for check-ups until now? ___________
2. Date of last check up. ___________
3. Date of last dental check up. ___________
4. Has your child had allergic reactions to any medications, foods, insect bites? No Yes
   which ones? ____
5. Has your child had reactions to any immunizations? No Yes
   Which ones? ____
6. Any hospitalizations other than for birth? No Yes
   For what? ____
7. Any serious injuries? No Yes
   What kind? ____
8. Are any medications taken regularly? No Yes
   Which ones? ____

C. FAMILY HISTORY:
1. Are the child's parents both in good health? No Yes
2. Circle any diseases that this child's parents, grandparents, brothers, sisters, or aunts and uncles have had:
   anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer, AIDS, or others: ____
3. List age, sex and general health of brothers and sisters: _____________
   ____
   ____
4. Have any of your children died? No Yes

D. FEEDING AND NUTRITION:
1. Is your child's appetite usually good? No Yes
2. Is it good now? No Yes
3. Was there severe colic or any unusual feeding problem during the first 3 months? No Yes
4. Do any foods disagree with him/her? No Yes
5. For the first 6 months, is he/she (was he/she) breast fed or bottle fed? __________________
6. If still on formula, which one do you use? __________________________
7. Does he/she take vitamins? No Yes

E. REVIEW OF SYSTEMS:
1. Has your child had frequent ear infections? No Yes
2. Any eye problems? No Yes
3. Has he/she had any problems with teeth? No Yes
4. Does he/she have frequent colds or sore throat? No Yes
5. Is there asthma, pneumonia or recurrent cough? No Yes
6. Does he/she have a heart murmur or any heart problems? No Yes
7. Any problems with urination? No Yes
8. Any problems with diarrhea or constipation? No Yes
9. Have there been any convulsions or other problems with the nervous system? No Yes
10. Any eczema, hives, or other skin conditions? No Yes
11. Has your child ever been anemic? No Yes
12. Please list any other medical problems: ______________________
    ____
    ____

F. DEVELOPMENT/BEHAVIOR:
1. At what age did your child sit alone? __________
2. At what age did he/she walk alone? __________
3. Did he/she say any words by the time he/she was 1 ½ years old? No Yes
4. How does this child compare to others his or her age?
   ____
5. Does he/she have any trouble sleeping? No Yes
6. What grade is he/she in? __________
7. Has he/she any trouble in school? No Yes
8. Does he/she get along with other children? No Yes
9. Circle if your child has had any of the following:
   nail biting, thumb sucking, bed wetting, problem with toilet training, bad temper, hyperactivity, nightmares, speech problems, problems with discipline, or others: ______________________________

G. SAFETY/ENVIRONMENT:
1. Do you live in a private house, apartment, mobile home, other?(**circle**)
2. Do you know the hottest temperature of the water in your pipes? No Yes
3. Is there a working smoke alarm on each floor in the house? No Yes
4. Does your child always use a car seat/ seat belt when riding in a car? No Yes
5. Are there any smokers in the house? No Yes
6. Are there any problems with the condition of your home? No Yes
   (peeling paint, insects, rats, or mice) No Yes
7. Does your child always wear a helmet when riding his/her bicycle? No Yes

H. DO YOU HAVE A RECORD OF IMMUNIZATION? No Yes