LONE STAR PEDIATRICS
12120 RR 620
Austin, Texas 78750
(512) 833-PEDI (7334)
After Hours: (512) 323-5465

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: ____/____/____ Sex: ☐ F ☐ M

Your name: _____ Relationship to child: _____

Where do you live? _____ Who is the legal guardian: _____

How long has the child been in your care? _____ Referring Physician: _____

Mother's name: _____ Age: _____ Occupation: _____

Years of Schooling completed: _____

Father's name: _____ Age: _____ Occupation: _____

Years of Schooling completed: _____

Child lives with: ☐ Parents ☐ Mother ☐ Father ☐ Other Parents: ☐ Married ☐ Divorced

Number of adults living in the home: _____ Number of children living in the home: _____

Please list the names and ages of brothers and sisters:

Name: _____ Age: _____ Name: _____ Age: _____

Name: _____ Age: _____ Name: _____ Age: _____

Pets: _____ Type: _____ Type of home: ☐ Apartment ☐ Trailer ☐ House

Smokers in Household? ☐ Yes ☐ No Who? _____

Water Source: ☐ City ☐ Well ☐ Bottled ☐ County

What children's health reference books do you have in your personal library? _____

MEDICAL HISTORY

Pregnancy History: Did patient's mother use any of the following substances or have any of the following symptoms during pregnancy?

	Y	N	Don't Know	DOCTOR'S NOTES
Medications: Please name:				
Street drugs: Please name:				
Alcohol				
Smoking				
Vaginal infection				
Urine infection				
Other Problems:				

Birth History:

How long was the pregnancy?	
What hospital was the baby born at?	
What was the baby's birthweight?	
How long did the baby stay in the hospital?	
Was the delivery vaginal? ☐ Yes ☐ No ☐ Don't know	
Did the baby have any problems? ☐ Yes ☐ No ☐ Don't know	

Medical History, continued....	Y	N	Don't Know	DOCTOR'S NOTE
Has your child ever been hospitalized overnight?				
Has your child ever had surgery?				
Does your child have allergies? To What?				
Does you child get regular dental care?				
If your child is on any medication? Please List:				
Has your child gone to an ER this past year?				
Has your child ever had:				
Ear Infection?				
More than 2 Strep Throat?				
Pneumonia?				
Heart Problems?				
Chickenpox?				
Any major illness?				
Reaction to any immunization or medications?				
Urinary tract infections?				
Wheezing?				

Family History: Check if close blood relatives have the following:

Disease	Y	N	Who?	Disease	Y	N	Who?
Asthma				Heart Attack < 50 yrs.			
Sickle Cell Disease				Urine Infections			
Cystic Fibrosis				Hay Fever			
Tuberculosis				High Blood Problems			
Kidney Infection				Learning Problems			
Diabetes				Seizures			
Hyperactivity				Emotional Problems			
Sudden Death				Born w/Heart Problems			
Birth Defects				Death Shortly After Birth			

School / Daycare Behavior History

Child's School:_____Grade:_____

	Y	N	Don't Know	DOCTOR'S NOTE
Does child attend special classes or receive special help?				
Are you concerned about school behavior problems?				
Frequent nightmares?			N/A	
Difficult to control?			N/A	
Fighting a lot?			N/A	
Trouble making friends?			N/A	
Bedwetting or stooling problems?			N/A	
Vision / Hearing			N/A	
Appetite?			N/A	

Name of child's previous doctor: _____

Address: _____

Are there any specific issues you would like to discuss with your doctor? _____

_____

Signature of person completing for:_____ Date: _____ Relationship to patient _____

Reviewed by Dr.: _____Date: _____

Updated 6/1/2011