Better Health Medical Center
New Patient Questionnaire

Name:_____D.O.B._____
Address:_____
Phone:_____
SSN_____

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 any illness during pregnancy? No **Yes**
3. Did she take any medications other than vitamins and iron? No **Yes**
4. Was the baby on time? **No** Yes
5. What was the babies birth weight?_____ Length?_____
6. Did the baby have any trouble starting to breath? No **Yes**
7. Did the baby have any trouble while in the hospital? (jaundice, infections, other?) No **Yes**
What kind? _____
_____

B. PAST MEDICAL HISTORY
1.Where has your child gone for check-ups until now? _____
2. Date of last check: _____
3. Date of last dental check-up: _____
4. Has your child had allergic reactions to any medications, foods or insect bites? No **Yes**
Which ones_____
5. Has your child had reactions to any immunizations? No **Yes**
6. Any hospitalization other than for birth? No **Yes**
7. Any serious injuries? No **Yes**
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, aunts or uncles have had: ANEMIA ASTHMA HIGH BLOOD PRESSURE HEART TROUBLE MENTAL ILLNESS DRUG PROBLEMS ALLERGIES ALCOHAL PROBLEMS INHERITED ILLNESS VENERAL DISEASE CANCER AIDS 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 three months? No **Yes**
4. Does any food disagree agree with him/her? No **Yes**
5. Is/was he/she breast-fed? No Yes
5.a. If breast fed, how long? _____
6. If on formula, which one do you use? _____
7. Does he/she take vitamins? No Yes

Mother_____Age_____
Occupation_____Wk#_____
Father_____Age_____
Occupation_____Wk#_____

Comments_____
_____
_____See reverse □

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 throats? 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 and 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 had 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 BAD TEMPER PROBLEMS WITH TOILET TRAINING HYPERACTIVITY NIGHTMARES SPEECH PROBLEMS PROBLEMS WITH DISCIPLINE OTHERS

G. SAFETEY/ENVIROMENT
1. Do you live in a PRIVATE HOUSE APARMENT 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 of 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 your household? No **Yes**
6. Are there any problems with the condition of your home? No **Yes**
7. Does you child always wear a helmet when riding his/her bicycle? **No** Yes.

H.DO YOU HAVE A RECORD OF IMMUNIZATIONS **No** Yes