

## Mesquite Pediatrics New Patient Questionnaire

Mother's Name \_\_\_\_\_ Age \_\_\_\_\_ Patient Name \_\_\_\_\_

Father's Name \_\_\_\_\_ Age \_\_\_\_\_ Patient Date of Birth \_\_\_\_\_

### Family History

Siblings' Names: \_\_\_\_\_

Are the child's parents both in good health? \_\_\_\_\_

Check any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Allergies                   | <input type="checkbox"/> Diabetes         |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Heart disease before age 50 | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Seizures            | <input type="checkbox"/> Cancer                      | <input type="checkbox"/> Tuberculosis     |
| <input type="checkbox"/> Kidney Stones       | <input type="checkbox"/> Sudden unexplained death    | <input type="checkbox"/> Mental Illness   |

List any other significant chronic illnesses in the family: \_\_\_\_\_

Is there a smoker in the household? Yes No

Do both parents live at home? Yes No If "No", with whom does the patient live? \_\_\_\_\_

Is there a gun in the household? Yes No If "Yes", is it securely locked? Yes No

### Pregnancy and Birth

Mother's age at child's birth \_\_\_\_\_

Did mother have an illness during pregnancy? Yes No List the illness: \_\_\_\_\_

Did she take medications other than vitamins? Yes No List the medication: \_\_\_\_\_

Was the baby premature? Yes No If "Yes", the baby was born at \_\_\_\_\_ weeks

What was the birth weight? \_\_\_\_\_

What type of delivery? Vaginal C-Section

Did the baby have trouble while in the hospital? Yes No If "Yes", what kind of trouble? \_\_\_\_\_

### Past Medical History (these questions refer to the child)

Any allergic reactions to medications, foods, or insect bites or stings? Yes No Which ones? \_\_\_\_\_

Any reactions to immunizations? Yes No Which ones? \_\_\_\_\_

Any hospitalizations? Yes No Why, at what age? \_\_\_\_\_

Any surgeries? Yes No What kind, at what age? \_\_\_\_\_

Any serious injuries? Yes No What kind, at what age? \_\_\_\_\_

Any medications taken regularly? Yes No Which ones? \_\_\_\_\_

Check any medical problems your child has had:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Ear Infections	<input type="checkbox"/> Frequent Strep Throat
<input type="checkbox"/> Constipation	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Allergies
<input type="checkbox"/> Vision/Hearing Problem	<input type="checkbox"/> Seizures	<input type="checkbox"/> Heart Problems
	<input type="checkbox"/> Urinary Tract Infections	<input type="checkbox"/> Anemia

List any other medical problem your child has that is not listed above: