The Portland Clinic

New Pediatric Patient Questionnaire

(To be completed by parent)

Parent Name _____ DOB _____

Occupation _____

Parent Name _____ DOB _____

Occupation _____

Guardian Name _____ DOB _____

Occupation _____

❑ Married ❑ Divorced ❑ Other _____

If adults work outside the home, what childcare arrangements are made for this child?

_____

Pregnancy & Birth

Mother's age at birth? _____

Did mother have any illness during pregnancy? ❑ yes ❑ no

If yes, list

_____

Did mother take any medications other than vitamins & iron? ❑ yes ❑ no

If yes, list

_____

Was the baby on time? ❑ yes ❑ no

If no, how late or early? _____

What was baby's birth weight? _____ lbs _____ oz

Did baby have any trouble starting to breath? ❑ yes ❑ no

Did baby have any trouble while in the hospital? ❑ yes ❑ no

(jaundice, infections, etc) If yes what problems? _____

_____

Past Medical History

Where has your child gone for medical care until now?

_____

Date of last check-up _____

Has you child had any allergic reactions to medications, foods, insect bites? ❑ yes ❑ no

If yes, to what? _____

Any hospitalizations other than birth? ❑ yes ❑ no

If yes, for what? _____

Please list any serious injuries _____

List any medications your child takes regularly

_____

_____

Family Medical History

Are the child's parents both in good health? ❑ yes ❑ no

If no, list _____

_____

List of siblings and dates of birth

_____ _____

_____ _____

_____ _____

Place patient sticker here or

Childs name _____

Date _____

Medical Record Number _____

Have any of your children died? ❑ yes ❑ no

Check any diseases that this child's parents, grandparents, siblings, aunts or uncles have had:

❑ Anemia	❑ Asthma	❑ Allergies
❑ Diabetes	❑ High blood pressure	❑ Drug or alcohol problems
❑ Tuberculosis	❑ Mental illness	❑ Heart trouble
❑ Inherited illness	❑ Venereal disease	❑ Cancer
❑ AIDS	❑ Other: _____	

Review of Systems

Has your child had frequent ear infections?	❑ yes ❑ no
Any eye problems?	❑ yes ❑ no
Any dental problems?	❑ yes ❑ no
Frequent colds or sore throats?	❑ yes ❑ no
Asthma, pneumonia or recurrent cough?	❑ yes ❑ no
Heart murmur or heart problems?	❑ yes ❑ no
Problems with urination?	❑ yes ❑ no
Diarrhea or constipation?	❑ yes ❑ no
Convulsions or nervous system problems?	❑ yes ❑ no
Eczema, hives or other skin problems?	❑ yes ❑ no
Has your child been anemic?	❑ yes ❑ no

Please list any medical problems below:

_____

_____

_____

Development & Behavior

At what age did your child sit up alone? _____

At what age did your child walk alone? _____

Did he/she say any words by 1 ½ years of age? ❑ yes ❑ no

How does this compare to siblings at his/her age?

_____

What grade is he/she in? _____

Does he/she have trouble sleeping?	❑ yes ❑ no
Has he/she had any trouble in school?	❑ yes ❑ no
Does he/she get along with other children?	❑ yes ❑ no

Safety & Environment

Do you live in a private house, apartment, mobile home or other? (please circle)

Do you know the hottest temperature of your water tank? ❑ yes ❑ no

Is there a working smoke alarm on each level of your house? ❑ yes ❑ no

Does your child always use a car seat/seat belt? ❑ yes ❑ no

Are there any smokers in the household? ❑ yes ❑ no

Any problems with the condition of your home? (peeling paint, rats, insects, mice) ❑ yes ❑ no

Does your child always wear a helmet when riding his/her bicycle? ❑ yes ❑ no

Do you have current immunizations records? ❑ yes ❑ no