Kids First Pediatric Clinic, LLC
18676 Willamette Dr. Suite 300, West Linn, OR 97068
Phone: (503) 699-3313 Fax: (503) 699 – 3365
www.kidsfirstclinic.com

NEW PATIENTQUESTIONNAIRE

Patient's Name____DOB:__________________Today's Date _________

Mother's Name___________________________Age___Father's Name___________________________Age ____

PREGNANCY AND BIRTH

Mother's at child's birth __________

What number pregnancy was this child? ______

Did mother have any illness during pregnancy? Y N

Did she take any medications other than vitamins and iron? Y N

If yes, what? ________________________

Was the baby on time? Y N
If no, how early was your baby? ________________

Were there any complications with the baby during delivery?______________________________

Was the delivery **vagina**l or by **C-section**?_________

Did the baby go home at the same time as mom? Y N

Did the baby have any trouble while in the hospital?

(Jaundice, Infections, other?) ____________________

Did the baby go to the NICU? Y N

If yes, please give a brief synopsis of the course:

If so, how long were they there? ____________

If on ventilator, how long? ________________

If on oxygen, how long? __________________

Other info (infections, surgeries, interventions) while in NICU:

____

____

Birth Weight Birth Length

Are your child vaccinations up to date? Y N

If not, why?___________________________________

____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y/N

Was there severe colic or any unusual feeding problems during the first 3 months? Y/N

Do any foods disagree with him/her? Y/N

If so, what? ___________________________________

For the first 6 months, is (s)he was breast-fed or bottle-fed?

If still on formula, which one? ___________________

Does (s)he take vitamins? Y/N

DEVELOPMENT/BEHAVIOR

How does child compare to others of same age?

____

Does child haven any of the following? (circle all that apply)

Thumb sucking Nail biting

Bed wetting Bad temper

Problems with toilet training

Hyperactivity Problems with discipline

Nightmares Speech problems

Other_________________________________

X _____ Initials

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Has your child had any of the following medical problems? Please circle one

Serious injuries or accident
Hospitalization
Surgeries
Chickenpox disease
Hearing loss
Anemia or bleeding problem
Kidney problem
Eczema
Learning disorder
Frequent ear infection
Heart problem or murmur
Blood transfusion
Bladder of kidney infection
Bedwetting (after 6 years of age)
Use of alcohol or drugs
Constipation requiring Dr. Visits
Asthma/ wheezing/ pneumonia
Allergies-seasonal, animals, indoor, foods
Allergic reactions- medications, vaccinations
Frequent headaches, convulsions of other neurological problems
Diabetes/ blood sugar problems
Thyroid or other endocrine problems
Other significant problems

PAST MEDICAL HISTORY

- Where has your child gone for check-ups until now? ______________________________
- Date of last Check-up ____________________
- Date of last dental check-up ____________________
- Are any medications taken regularly? Y N
- Please list names, dosages and frequency taken?
- ______________________________
  ____
  ____
- If female, have periods started? ______________________________
- When? ______________________________

FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins or grandparents)

Spina Bifida	vision/eye problems
Bone disorder	cerebral Palsy
Cleft lip/palate	ADD/learning disorder
Hearing loss/deafness	Convulsions
Heart disease/defect	Infertility
Neurofibromatosis	Limb defects
Mental retardation	Down Syndrome
Neurological disorder	Cystic fibrosis
Mental Illness	Short stature (<5ft)
Tuberculosis	Diabetes
Hay fever/allergies	Drug/alcohol problems
Sickle Cell Anemia	Bleeding disorder
Muscle disorder	Kidney disease
Skin disease	Genital abnormality
High blood pressure	Asthma
Urinary tract abnormality	AIDS (HIV)

High cholesterol/triglycerides

Chromosome abnormality

Brain anomalies (includes Hydrocephaly)

Anemia (includes Thalassemia)

Patient's mother was exposed to DES

Other birth defect/malformations/problems?

Please list:______________________________________
____

List age, sex, and health problems of brothers and sisters (are they living)?

____
____