UNIVERSAL PEDIATRIC ASSOCIATES
PEDIATRIC NEW PATIENT QUESTIONNAIRE

Patient Name_____ **DOB:**_____

Parents:(Mom)_____ **DOB:**_____ **Occupation**_____

Country of Birth_____

(Dad)_____ **DOB:**_____ **Occupation**_____

Country of Birth_____

Siblings: _____ **AGE:**_____

_____ **AGE:**_____

_____ **AGE:**_____

_____ **AGE:**_____

LANGUAGE(S) SPOKEN AT HOME:_____

PARENTS: Married_____ **Never married**_____**Separated**____**Divorced**_____

RELIGION (Optional)_____

BIRTH HISTORY:

Complications with birth or pregnancy? _____

Full term?_____ **If not, how may weeks?**_____

Vaginal or C section (please circle one)

Birth Weight:_____ **Breastfed or bottle? (please circle one).**

PAST MEDICAL HISTORY:

Medical problems (including hospitalizations):

_____

Surgeries (include year)_____

CURRENT MEDICATIONS AND DOSES:

_____ _____ _____

MEDICATION ALLERGIES and REACTION:

_____

FAMILY MEDICAL HISTORY:

PATIENT'S MOTHER:_____

PATIENT'S FATHER:_____

BROTHERS:_____

SISTERS:_____

For Grandparents: (Do not list if disease occurred over the age of 65)

MATERNAL GRANDMOTHER:_____

MATERNAL GRANDFATHER:_____

PATERNAL GRANDMOTHER:_____

PATERNAL GRANDFATHER:_____

PLEASE CHECK IF YOUR CHILD HAS HAD ANY OF THE FOLLOWING:

_____**Skin conditions, eczema**
_____**Eye problems(glasses)**
_____**Anemia**
_____**Difficulty with speech/hearing**
_____**Difficulty with learning**
_____**Heart murmur/palpitations**
_____**Abuse(physical/mental/sexual)**
_____**Frequent headaches (migraines)**
_____**Eating disorder (anorexia/bulimia)**
_____**Constipation/stool withholding**
_____**Kidney or bladder infections**
_____**Excessive bleeding/easy bruising**
_____**Asthma**
_____**Problems with periods**
_____**Seizures**
_____**Developmental delay**
_____**Pneumonia**
_____**Blood in protein or urine**
_____**Trouble gaining weight**
_____**Trouble losing weight**
_____**Frequent sinus infections**
_____**Frequent stomachaches**
_____**Bedwetting**
_____**Lead poisoning**
_____**Broken bones/stitches**
_____**Depression/anxiety**
_____**Chicken pox (Date:_____)**
_____**Dizziness/fainting**
_____**Blood in stool**
_____**Frequent diarrhea**
_____**Allergies**
_____**Frequent ear infections**
_____**Frequent nose bleeds**
_____**Food Allergies**