Village Pediatrics, LLC: *New Patient Questionnaire*

Date: ________________

Patients Name: ____________________________________ ***DOB:*** ________________

Newborn/Neonatal History: (Please Check/fill in appropriate information)

Adopted: (Yes__/No__)
Any known history: (Yes__/No__) If so please fill in the following.

Pregnancy:

Normal (Yes__/No__) Number of week gestation___________________________
Complications: Premature Labor ___ Preeclampsia ___ Infection ___ Other ______________________________
Alcohol (Yes__/No__) Smoking (Yes__/No__) Substance use (Yes__/No__) ________________________
Medications/Vitamins ____

Birth History:

Home Birth (____) Birthing Center (____) Hospital (____)
Name of facility and Doctor/Midwife/Practitioner: ____
Delivery Type: Normal Vaginal (____) Forceps (____) Suction (____) VBAC (____)
C-Section Routine/Scheduled (____) Emergency (____) Please Explain: _____________________
Birth Weight: __________ Discharge Weight: __________
Hepatitis B Vaccine given at birth (Yes__/No__) Vitamin K (Yes__/No__) Eye Ointment (Yes__/No__)
Blood Type: Mother _____ Baby _____ Coombs: Positive _____ Negative _____
Newborn Nursery (____) Neonatal Unit (____) Length of stay ____
Breastfed (____) Formula: which kind ____
Feeding Problems ____
Jaundice/Hyperbilirubinemia (____) Phototherapy # day's ____
Respiratory: TNN (____) Pneumonia (____) Ventilator (____) CPAP (____) O2 (____)
Infection: Group B Strep (____) R/O Sepsis (____) Antibiotics (____) # of day's ____________________________
Anemia (____) Transfusions (____) Newborn Screening Performed (Yes__/No__)
Circumcision (Yes__/No__) Planning but not performed yet (____) Hearing Screening (Pass__/Fail __)
Other Important information: ____

Has your child had any of the following? (Please Check/fill in appropriate information)

ENT: Ear Infections (____) Hearing Loss (Left____) (Right____) Other ear issues ___________________________
Throat Infections (____) Strep (____) other throat issues____
Nose bleeds (____) Allergic Rhinitis (____) Chronic Sinus Infections (____) Sleep Apnea (____)
Other Nose Issues ____
Cardiac: Heart Defect (____) Type _______________ Heart Murmur (____) Type ___________________________
Arrhythmia (____) Other Heart/Cardiac Issues ____
Respiratory: RSV (____) Bronchitis/Bronchiolitis (____) Asthma (____) Cystic Fibrosis (____) Pneumothorax (____) Pneumonia (____)
Type ________________ Required Hospital Stay(Yes__/No__)
Other Respiratory Issues ____
Gastrointestinal: GERD (____) Constipation (____) Chronic Diarrhea (____) Other ___________________________
Genitourinary: Hernia (____) Hydrocele (____) Bedwetting (____) UTI (____)
VCUG/Ultrasound/Renal Scan (Yes__/No__) Results/Procedures ____
Dermatological: Skin Infections (____) Eczema (____) Acne (____) Other________________________________
Allergies: Medication (____) Environmental (____) Food (____) Specify__________________________________
Endocrine: Diabetes: (____) Type I (____) Type II (____) Age of Diagnosis ___________________________________
Hypothyroidism (____) Hyperthyroidism (____) Other____
Hematology/Oncology: Anemia (____), Bleeding Disorders (____) Type ________________________________ Cancer (____)
Type_____________________________ Other ____
Neurology/Psychology/Developmental: Seizures (____) Type _________________ Low Tone (____)
Hyper Tone(____)OCD(____) Cerebral palsy (____) Autism(____) Asperger Syndrome(____) ADD/ADHD (____) Bipolar Disorder(____)Anxiety (____) Delayed(____) Speech/Language (____) Behavioral Issues (____)
Other ____
Genetic Disorders: Specify ____

(Over)

Surgery: (List dates/hospital/type)

____
____

Hospitalizations: (List dates/hospital/reason)

____
____

Injuries/Fractures: (Date/Treatment)

____
____

Medications/Supplements:
Past____
Present ____

Immunizations: Up to Date (Yes__/No__) Delayed (Yes__/No__) Religious Exempt (Yes__/No__)

Education: Grade _____ School _________________________ Performance _________________________________
Additional Assistance ______________________________ Sports/Activities _________________________________

Pets: (Yes__/No__) Type ____

Does anyone in the Family smoke? (Yes__/No__) Who? ____
Inside or Outside? ____

Social: Parents: Married (____) Together (____) Separate (____) Divorced (____) Blended family (____)
Child (children) live with ____

Family History:
List significant history and whether or not relative is on maternal (M) or paternal (P) side.
Mother adopted (____) Father adopted (____)

Heart Attack (____) (____) Stroke (____)(____) High Blood Pressure (____) (____) High Cholesterol (____) (____) Aneurysm (____)(____) Blood Disorders (____)(____) Diabetes (____)(____) Type: Juvenile/ Adult
Obesity (____) (____) Alcoholism (____) (____) Other substance abuse (____) (____)
Mental Illness: specify (____) (____) Other problems: ____

List immediate family members, age and whether or not they have health issues:

____
____
____

Any other information you would like to share?

____
____

I have had the opportunity to review the Notice of Privacy and have no other questions.

Signature ____ Date ________________________________

Witness ____ Date ________________________________