New Patient Questionnaire

Date: _____

Child's Name: _____ DOB: _____

How did you hear about Start Line Pediatrics? _____

Who does the child live with?

☐ Both Parents ☐ Single Parent ☐ Adoptive Parents ☐ Foster Family

☐ Other Family / Friend

Please list members of current household:

Name	Relationship to Child	Date of Birth	Health Problems
Parent:			
Parent:			

If both parents are not living in the home, how often does the child see the parent(s): _____

_____

Are there siblings not listed? If so, please list their names, ages, and where they live:

_____

Any significant issues with pregnancy or birth history we should know about? _____

_____

_____

Any medication, food, animal, environmental allergies? _____

_____

Does your child have any chronic illnesses / medical conditions? _____

_____

_____

Current Medication(s) and dose? _____

_____

_____

Any past Hospitalizations / surgeries? _____

_____

_____

Is there anything else you would like us to know about your child? _____

_____

Family History:

☐ ADHD	Relationship to child: _____
☐ Anemia	Relationship to child: _____
☐ Arthritis	Relationship to child: _____
☐ Asthma	Relationship to child: _____
☐ Birth Defects	Relationship to child: _____
☐ Bleeding Disorder	Relationship to child: _____
☐ Cancer	Relationship to child: _____
☐ Depression / Anxiety	Relationship to child: _____
☐ Developmental Delay	Relationship to child: _____
☐ Diabetes (Type I or II?)	Relationship to child: _____
☐ Drug / Alcohol addiction	Relationship to child: _____
☐ Hearing Loss	Relationship to child / Reason: _____
☐ Heart Disease	Relationship to child / Type: _____
☐ High Cholesterol	Relationship to child: _____
☐ Kidney Disease	Relationship to child: _____
☐ Liver Disease	Relationship to child: _____
☐ Migraines	Relationship to child: _____
☐ Seasonal Allergies	Relationship to child: _____
☐ Seizures	Relationship to child: _____
☐ Sudden Infant Death	Relationship to child: _____
☐ Thyroid Disorder	Relationship to child: _____