

Start Line Pediatrics

New Patient Questionnaire

Child's Name: _____ Child's Date of Birth: _____ Today's Date: _____

How did you hear about Start Line Pediatrics? _____

Members of Household	Relationship to Child	Date of Birth

Does your child spend time living with any other guardians / adults / relatives? Please describe.

Are there siblings not listed above? If so, please list their names, date of birth, and where they live.

Any pregnancy or birth history we should know? Was your child in the NICU?

Any allergies?

Any long-term medical problems?

Any prescription medications? If so, please list medication and dosage and why it is prescribed

Any over the counter supplements? If so, please list supplement and dosage

Has your child ever been hospitalized?

Has your child ever had surgery (including newborn circumcision)?

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

Family Medical History

Medical Condition	Patient's Mother	Patient's Father	Patient's Sibling	Mother's Parent or Sibling <i>Please specify</i>	Father's Parent or Sibling <i>Please specify</i>
ADHD					
Allergies					
Anemia					
Arthritis					
Asthma					
Autism Spectrum Disorder					
Bleeding Disorder					
Cancer (diagnosed < 50 years old)					
Celiac Disease					
Congenital Anomalies (Birth Defects)					
Congenital Heart Disease					
Crohn's Disease or Ulcerative Colitis					
Cystic Fibrosis					
Drug or Alcohol Use Disorder					
Hearing Loss (as a child)					
Heart Attack or Stroke (at <55 years old if male or <65 years old if female)					
High Blood Pressure					
High Cholesterol					
Hip Dysplasia					
Kidney problems					
Learning Problems or Developmental Delay					
Mental Health (ex. anxiety, depression)					
Migraines					
Neonatal Jaundice requiring phototherapy					
Seizures					
Sickle Cell					
Thalassemia					
Thyroid Problems					
Type I Diabetes					
Type II Diabetes					
Vision or Eye Problems (<5 years old)					
Other:					
Other:					