New Patient Questionnaire

Thank you for choosing Mid-Kansas Pediatric Associates, P.A. as the source of your child's health care. To help us know your child, please take a few minutes to answer the following questions. (All information is, of course, confidential.) If your child is a newborn, please answer questions 1, 3, 10 and 12 and those on the other side of this page.

1. *Child's Name*_____ *Birth Date* _____
2. *Child's previous source of health care* _____
3. *Who referred you to our office?* _____
4. *Medication Allergies* _____
5. *Is your child currently on any medication? __no __yes If yes, please list names and dosages:*

   _____
6. *Does your child currently see any other specialist (e.g. allergist, neurologist, ophthalmologist)?*

   __no __yes If yes, please list: _____

   *Why?*_____
7. *Does your child have any ongoing or past health problems (e.g. asthma, allergies, seizures, diabetes)?*

   __no __yes Please list: _____
8. *Has your child ever been hospitalized overnight or had any surgical procedures? __no __yes If yes, at what age and why or what procedure?*_____

   _____
9. *Has your child broken any bones? __no __yes Please list bone(s) and date(s):*_____

   _____
10. *Are your child's immunizations up-to-date? __no __yes Please list shot dates below or give your shot record to the receptionist to make a copy.*

    DTP _____ *Chicken Pox* _____

    OPV _____ *Prevnar* _____

    Haemophilus Influenza Type B _____ *Td* _____

    Hepatitis B _____ *Influenza* _____

    MMR _____ *Other* _____
11. *Has your child ever had a severe immunization reaction? __no __yes Please record which immunization and date on 10.*
12. *Are there other children in your family? __no __yes If yes, please list the names and dates of birth. If half-siblings, please indicate whether the child is related to mother's or father's side.*

    _____ *(OVER)*

Child's Name _____ *Birth Date* _____

Is there anyone in your family (including your child's parents, grandparents, siblings, aunts, uncles, and cousins) with a history of:

	No	*Yes*	*How Related to Child (maternal or paternal)*
Sudden Infant Death Syndrome (crib death)	__	__	_____
Birth Defects or Abnormalities	__	__	_____
Cystic Fibrosis	__	__	_____
Asthma or Wheezing	__	__	_____
Allergies (including hayfever)	__	__	_____
Febrile Seizures, Seizures or Epilepsy	__	__	_____
Hearing Problems (present at birth or at a young age)	__	__	_____
Diabetes	__	__	_____
Kidney Problems	__	__	_____
High Blood Pressure	__	__	_____
Autism	__	__	_____
Thyroid Disease (high or low)	__	__	_____
Depression	__	__	_____
Alcoholism	__	__	_____
Drug Abuse	__	__	_____
Heart Attacks, Strokes or Hardening of the Arteries Under Age 55	__	__	_____
High Cholesterol	__	__	_____
Sickle Cell Disease	__	__	_____
Bleeding Problems	__	__	_____
Cigarette Smoking	__	__	_____

Is there anything else we should know about your child or family's medical history?

_____

_____