Ivy Pediatrics
Infant, Child, & Adolescent Medicine

New Patient Questionnaire

First, print out this form. Fill it out. Bring it with you to our office.

Patient Name ____ DOB ________________
City/Country of birth ____

Pregnancy & Birth

Mother's age at child's birth _______
Maternal illness during pregnancy or early labor? If "yes", list: _____________________________________
Did she take medications other than vitamins If "yes", list ______________________________________
Was the baby born <37 or >41 wks gestation? If "yes", the baby was born at ________ weeks
What was the birth weight? _____________
What type of delivery (check) ___ Vaginal ___ ceasarian ___ vacuum ___ forcep
Did the baby have trouble while in the hospital? If "yes", list: ______________________________________
(infection, jaundice, breathing difficulties, NICU) ______________________________________

Vaccination Status (please circle): Up-to-date **Delayed** **Not Immunized**
if delayed or not immunized explain:____

Past Medical History (refers to child)

Any allergic reactions to medications, foods, insect stings, or immunizations? If "yes", which ones? ________________________________
Any overnight hospitalizations? If "yes", why and at what age? ______________________________________
Any surgeries? If "yes", what kind, at what age? ____________________________________
Any serious injuries? If "yes", what kind, at what age? ____________________________________
Any medications taken regulary? If "yes", which ones? ____
(other than cold medicines/pain relievers)

Check any medical problems your child has had:

☐ Urinary Tract Infections ☐ Asthma ☐ Frequent Strep Throat
☐ Frequent Ear Infections ☐ Pneumonia ☐ Anemia ☐ Heart Problems
☐ Vision/Hearing Problems ☐ Environmental Allergies ☐ Seizures ☐ School Problems
☐ Emotional/Behavior Problems ☐ Speech Problems ☐ Constipation ☐ Lyme Disease

List any other medical problems your child has had that are not listed above ______________________________
____

Family History

Check any diseases that the child's parents, siblings, grandparents had and indicate who had it:

☐ Asthma ☐ Allergies ☐ Diabetes ☐ Seizures
☐ Hypertension ☐ Heart disease before age 50 ☐ High cholesterol ☐ Cancer
☐ Tuberculosis ☐ Kidney stones ☐ Mental Illness ☐ Thyroid
☐ Sudden unexplained death ☐ Genetic/inherited illnesses

List any other significant chronic illnesses in the family ____
Is there a smoker in the household? ____