# NEW PATIENT QUESTIONNAIRE

**Please list your children's names and dates of birth:**

**Name** _____ **D.O.B.** _____

**Name** _____ **D.O.B.** _____

**Name** _____ **D.O.B.** _____

**Name** _____ **D.O.B.** _____

1. **Children's History:**
   **Please list any hospitalizations, surgeries, or major conditions (cancer, diabetes, etc.) that affect any of your children.**

   **Please list any other minor conditions (asthma, seasonal allergies, heart murmur, prematurity, etc.) that any of your children are being treated/followed for.**

2. **Family History:**
   **Father** **Age _____ Smoker _____ Previous Marriage . . . Yes No**
   **Mother:** **Age _____ Smoker _____ Previous Marriage . . . Yes No**
   **Brother:** **Age _____ _____ _____**
   **Sister:** **Age _____ _____ _____**

   **Do any family members have these inherited conditions? (circle)**

| | | | |
|---|---|---|---|
| **Allergies** | **Blood Cholesterol (elevated)** | **Diabetes** | **High Blood Pressure** |
| **Anemia** | **Cancer** | **Drug or Alcohol Dependency** | **Mental Illness** |
| **Asthma** | **Depression** | **Heart Disease (before age 50)** | **Seizures** |

   **Other Inherited Diseases:** _____

3. **Please list any significant family stresses that may affect the health of your children (recent divorce, death in family, addiction issues).**

4. **Please list any developmental/behavioral concerns you have regarding your children.**

5. **Please list any educational concerns you have regarding your children.**