EAGLE PEDIATRICS @ LAKE JEANETTE - PATIENT QUESTIONNAIRE

Date: ____________ D.O.B. ____________
Child's Name ____________ Primary Care Provider ____________
Address: ____________
Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________
Parent's Names: ____________
If new, have you had your medical records transferred? ❑ Yes ❑ No (not applicable for newborns)

FAMILY PROFILE

Parents: ❑ Married ❑ Separated ❑ Divorced
Father's Age: ____________ Health: ____________
Mother's Age: ____________ Health: ____________
List child's brothers and sisters and their ages: ____________

Pets: ____________

FAMILY MEDICAL HISTORY

(Please check the following if present in your family)

❑ Anemia/Blood Disorder ❑ Aids
❑ Epilepsy/Seizures ❑ Migraines
❑ Asthma ❑ Cystic Fibrosis
❑ Heart Disease ❑ Sudden Infant Death
❑ Mental Retardation ❑ Muscular Dystrophy
❑ High Blood Pressure ❑ Birth Defects
❑ Drug Problem ❑ Tuberculosis
❑ Alcoholism ❑ Deafness
❑ Cholesterol ❑ Arthritis
❑ Cancer ❑ Diabetes

PREGNANCY AND BIRTH

Mother's age at pregnancy: ____________
Any illness during pregnancy? ❑ Yes ❑ No
Medications during pregnancy? ❑ Yes ❑ No
(excluding vitamins)
Smoking-Alcohol-Street Drugs during pregnancy?

Was baby early, late, one time? ____________
Type of delivery? ____________
Birth Weight: ____________ Length: ____________
Complications: ____________
Apgar Score: ____________
Problems at birth with:
Breathing: ❑ Yes ❑ No
Jaundice: ❑ Yes ❑ No
Other: ____________
Problems soon after? (Nursery or at home): ____________

PAST MEDICAL HISTORY

Allergic Reactions: ____________
Medicine? ❑ Yes ❑ No Animals? ❑ Yes ❑ No
Food? ❑ Yes ❑ No Insect Bites? ❑ Yes ❑ No
If yes, give details: ____________

Medications on regular basis? (excluding vitamins) ______

Immunizations up to date? ❑ Yes ❑ No
Hospitalizations (when/where/why)? ____________

Serious injuries (when/where)? ____________

Significant past history? ____________

DEVELOPMENT AND BEHAVIOR

Age at which child:
Sat alone? ____________
Walked? ____________
Used sentences? ____________
Toilet trained? ____________
Bicycled? ____________
Development compared to other children: ____________
Grade in school: ____________
Problems in school? ❑ Yes ❑ No
Learning problems? ❑ Yes ❑ No Explain: ____________

Problems getting along with other children? ❑ Yes ❑ No
Behavior Problems: ❑ Yes ❑ No
Bad Habits? ❑ Yes ❑ No Explain ____________

Bed wetting? ❑ Yes ❑ No
Nail biting? ❑ Yes ❑ No
Sleeping? ❑ Yes ❑ No
Hobbies, sports, social activities? ____________

Use of street or illegal drugs? ❑ Yes ❑ No

FEEDING AND NUTRITION

Appetite usually good? ❑ Yes ❑ No
Colic or feeding problems during first 3 months? ❑ Yes ❑ No
Formula? ❑ Yes ❑ No Brand: ____________
Vitamins? ❑ Yes ❑ No Brand: ____________
Special Diet? ❑ Yes ❑ No
ANY ISSUES YOU WOULD LIKE TO DISCUSS WITH THE DOCTOR: ____________