NEW PATIENT QUESTIONNAIRE:

Patient's name: _____ Date: _____

If parents work, what are the childcare arrangements? _____

PREGNANCY AND BIRTH:

Did mother have any illness during pregnancy? YES NO _____

Was the baby on time? YES NO _____

What was the birth weight? _____

Did the baby have any trouble while in the hosptal? YES NO _____

Which Hospital was the baby born? _____

PATIENT MEDICAL HISTORY:

Where has your child gone for check-ups until now?_____

Does the child have any allergic reactions to any medication, immunization or food? YES NO _____

Any hospitalizations other than birth? YES NO _____

Any serious injury or surgery? YES NO _____

Any medications or vitamins taken regularly? YES NO _____

FAMILY HISTORY:

Circle any diseases that this child's parents, grandparents, brothers, sisters, aunts, uncles have had: anemia, asthma, allergies, diabetes, high blood pressure, heart trouble, tuberculosis, mental illness, drug problems, alcohol problems, inherited illness, venereal disease, cancer AIDS, other: _____

Have any of your children died? YES NO _____

Are there any smokers in the household? YES NO _____

Do you have any pets? YES NO _____

REVIEW OF SYSTEMS:

Has your child had any frquent ear infections? YES NO _____

Any eye problems? YES NO _____

Has he/she had any problems with teeth? YES NO _____

Does he/she have any frequent colds or sore throats? YES NO _____

Is there asthma, pneumonia or recurrent cough? YES NO _____

Does he/she have heart murmur or any heart problems? YES NO _____

Any problems with urination? YES NO _____

Any problems with diarrhea or constipation? YES NO _____

Have there been any convulsions or other problems with nervous system? YES NO _____

Any eczema, hives, or other skin conditions? YES NO _____

Has your child ever been anemic? YES NO _____

Please list other medical problems: _____

_____

Comments: _____

_____

Belkys Bravo M.D., F.A.A.P. • 1920 Coral Way • Miami, FL 33145 • Tel: (305) 250-9910