CATALINA PEDIATRICS NEW PATIENT QUESTIONNAIRE

Patient Name ______________________________ Date of Birth ______________ Sex M F

Mother's Name ________________ Age ___ Father's Name __________________ Age ___

Siblings' Names ____

Family History

Are the child's parents both in good health? Yes No

Check any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

☐ Asthma	☐ Allergies	☐ Diabetes
☐ High Blood Pressure	☐ Heart Disease before age 50	☐ High Cholesterol
☐ Scizurcs	☐ Cancer	☐ Tuberculosis
☐ Kidney Stones	☐ Sudden unexplained death	☐ Mental Illness

List any other significant chronic illnesses in the family: ______________________________

Is there a smoker in the household? Yes No

Do both parents live at home? Yes No If "No", with whom does the patient live? ______________

Is there a gun in the household? Yes No If "Yes", is it securely locked? Yes No

Pregnancy and Birth

Mother's age at child's birth ________

Did mother have an illness during pregnancy? Yes No List the illness ____________________

Did she take medications other than vitamins? Yes No List the medications ________________

Was the baby premature? Yes No If "Yes", the baby was born at ______ weeks.

What was the birth weight? _____ lbs. _____ ozs. or ________ grams

What type of delivery? Vaginal C/Section

Did the baby have trouble while in the hospital? Yes No If "Yes", what kind of trouble? ____________

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Past Medical History (these questions refer to the child)

Any allergic reactions to medications, foods, or insect bites or stings? Yes No If "Yes", which ones? ____________

Any reactions to immunizations? Yes No If "Yes", which ones? ____________________

Any hospitalizations? Yes No Why, at what age? ____________________

Any surgeries? Yes No What kind, at what age? ____________________

Any serious injuries? Yes No What kind, at what age? ____________________

Any medications taken regularly? Yes No Which ones? ____________________

Check any medical problems your child has had:

		☐ Frequent Ear Infections	☐ Frequent Strep Throat
☐ Asthma	☐ Pneumonia	☐ Frequent Allergies	☐ Constipation
☐ Seizures	☐ Heart Problems	☐ Vision/Hearing Problem	
☐ Urinary Tract Infections		☐ Anemia	

List any other medical problem your child has that is not listed above: