NEW LIFE FAMILY MEDICINE, LLC
PEDIATRIC HEALTH QUESTIONNAIRE

Name: _____ DOB:_____ Age:_____ Sex: ☐ M ☐F

What is your preferred pharmacy? _____

CURRENT MEDICATIONS (Please bring in your medications if available)

Name of Medication	Strength of Medication	Dosing Instructions

ALLERGIES

☐ No Known Allergies ☐ Medication Allergies ☐ Environmental/Seasonal ☐ Latex

Allergy	Reaction

PAST MEDICAL HISTORY (Check all that apply)

☐ Acid Reflux/GERD ☐ ADHD ☐ Allergies ☐ Diabetes

☐ Anemia ☐ Epilepsy/Seizure Disorder ☐ Asthma ☐ Mood/Behavior Disorder

☐ Other (please list) _____

_____

PAST SURGICAL HISTORY

Date of Surgery (Operations)	Type of Surgery (Operations)

FAMILY HISTORY (Check all that apply)

☐ Asthma ☐ Dementia/Alzheimer's ☐ Depression ☐ Diabetes

☐ Heart Disease ☐ High Blood Pressure ☐ High Cholesterol ☐ Thyroid Disease

☐ Stroke ☐ Mental Illness ☐ Cancer (Please specify) _____

☐ Other (Please list) _____

SOCIAL HISTORY

Family Information

Mother's Name: _____ Mother's Occupation: _____
Father's Name: _____ Father's Occupation: _____

Siblings: ☐ Yes ☐ No Sibling Names and ages: _____
Guardian Name and Relationship (if applicable): _____
If parents live separately, where is the child's primary residence? _____
Who lives at home? _____

Are there pets in the home? ☐ Yes ☐ No If yes, specify _____

Does anyone in the home smoke? ☐ Yes ☐ No

Child Care and Education

Does this child attend child care? ☐ Yes ☐ No
If yes, what is the name of the child care center? If yes, how many hours per week?
_____ _____

Does this child attend school? ☐ Yes ☐ No
If yes, what is the name of the school? If yes, what grade?
_____ _____

Do you have concerns about your child's adjustment or performance in school? ☐ Yes ☐ No
If yes, please explain: _____
_____

Learning Needs

Is your primary language English? ☐ Yes ☐ No If no, indicate primary language _____
How would you like health information about your child/youth presented?

☐ 1:1 Conversation with health care provider ☐ Reading Materials ☐ Classroom ☐ Other
Who makes up your household? (check all that apply):

☐ Single Parent ☐ Two Parent Household ☐ Siblings ☐ Other (family) ☐ Other's (not family)

Interests/Hobbies/Recreational Activities

_____
_____

Tobacco Exposure (check all that apply)

☐ Patient is a smoker ☐ Smokers in the home ☐ Smoke ouside only

Activity (check all that apply)

☐ Exercise/Sports (Hours per day) _____ ☐ TV/Computer games (Hours per day) _____

☐ Internet (Hours per day) _____ ☐ Text Messaging (Hours per day) _____

Sleep (Check all that apply)

☐ Takes Naps ☐ Sleeps with parents ☐ Sleeps through the night ☐ Min. 8 hours nightly ☐ Sleep problems

Safety (Check all that apply)

☐ Bike helmet ☐ Rear facing car seat ☐ Front facing car seat ☐ Booster ☐ Seat belt ☐ Carbon Monoxide Detector

☐ Smoke Detector ☐ Radon Detector ☐ Firearms in the home ☐ Pool/Spa ☐ Pets/Animals-type & number _____

_____

CONCERNS

Please list any concerns regarding the health of this child in the space provided.

_____
_____
_____
_____
_____
_____
_____

Name and Relationship of Person Completing Form (print):

_____

Signature _____ Date: _____

We would like to thank you for taking the time to complete this form. Doing so provides us with the information necessary to make the most out of each and every healthcare visit.