Pediatric & Adolescent Care

Health questionnaire for newborns

Dear Parent:
By filling out this questionnaire, you give us a more complete record of your child. Answer any question you can. Don't worry about those you skip. We will discuss with you any items that either you or we believe should be explained more fully.

Full name of Child: ______________________________

Today's date: ______________________________

Do you have any specific concerns? ______________________________

____

Environment:

Please list the names and relationship of those individuals who live in your house:

____

Usual caretaker for your child: ______________________________

Are there smokers in the home? .... No______ Yes______

Was your house built before 1960? .... No______ Yes______

Do any household members come in contact with toxic chemicals or lead? .... No ______ Yes______

If yes, please describe: ______________________________

Family History:

1. Have any close relatives had problems with the following:

		Relationship to this child (parent, grandparent, sibling, etc,)
________	Allergies	______________
________	Anemia	______________
________	Asthma	______________
________	Bleeding tendency	______________
________	Cancer	______________
________	Chronic lung disease or frequent infections	______________
________	Deafness	______________
________	Diabetes	______________
________	Epilepsy	______________
________	Eye disorders	______________
________	High blood pressure	______________
________	Heart trouble	______________
________	Immunity weakness or disorder	______________
________	Kidney diseases	______________
________	Liver diseases	______________
________	Thyroid problems	______________
________	Tuberculosis	______________

2. Is the child's mother living and in good health? .... Yes________ No________

   Name ______________________________ and age ______________

3. Is the child's father living and in good health? .... Yes________ No________

   Name ______________________________ and age ______________

4. List ages, sex and general health of this child's brothers and sisters:

   Name______________________ Age____ Sex____ Health OK ______ Not OK _____

   Illnesses: ______________________________

   Name______________________ Age____ Sex____ Health OK ______ Not OK _____

   Illnesses: ______________________________

   Name______________________ Age____ Sex____ Health OK ______ Not OK _____

   Illnesses: ______________________________