Patient Name: _____

New Patient Questionnaire

Medical History

1. Birth history: Premature □ Yes □ No
   Any complications during pregnancy, delivery, or after birth? □ Yes □ No
   If yes, explain: _____
   _____
   _____
2. Surgeries or Hospitalizations: □ Yes □ No If yes, explain: _____
   _____
3. Allergies: □ Yes □ No If yes, explain: _____
   _____
4. Any medical conditions: □ Yes □ No If yes, explain: _____
   _____
   _____
5. Immunizations Up to Date □ Yes □ No If no, explain: _____
   _____

School/Development History

1. Development delays □ Yes □ No If yes, explain: _____
   _____
2. Grade: _____ Any school related problems □ Yes □ No If yes, explain: _____
   _____
   _____

Family History

Please check appropriate box and list family member with condition

□ Asthma _____ □ Diabetes _____
□ High Cholesterol _____ □Heart disease <50yr _____
□ Hypertension _____ □ Kidney disease _____
□ Heart disease _____ □ Liver disease _____
□ Blood disease _____ □Cancer _____
□ Depression/anxiety _____ □ADHD _____
□ Learning problem _____ □ Drug allergy _____
□ Any other medical history _____
_____