Name: _____

DOB: _____ MRN: _____

Date: _____/_____/_____

MCV Hospitals and Physicians
VCU Health System
Richmond, Virginia 23298

Pediatric
NEW PATIENT QUESTIONNAIRE

PRIOR MEDICAL CARE / OTHER PRACTICES:

Name of Practice/Specialty:			
Address:			
Phone number:			
Reason for leaving (if applicable):			

MOTHER'S PREGNANCY HISTORY:

Prenatal Care? Yes / No Started during which month?
Problems during pregnancy?
Infections during pregnancy?
Medication during pregnancy?
Smoking? Yes / No
Drug use? Yes / No
Alcohol Use? Yes / No

CHILD'S BIRTH HISTORY:

Hospital born at
Born on time / early # of weeks early_____
Delivery: Vaginal / C-section
Problems during or after delivery?
Birth weight:
Number of days in hospital?

PAST MEDICAL HISTORY:

Check if your child has been diagnosed with the any of the following:

- ☐ Birth defects
- ☐ Breathing problems (asthma, bronchiolitis)
- ☐ Yellow jaundice
- ☐ Anemia
- ☐ Feeding problems
- ☐ Chicken pox
- ☐ Bleeding problems
- ☐ Heart problems
- ☐ Learning problems
- ☐ High lead or other toxin exposure
- ☐ Skin problems (eczema, acne)
- ☐ Pneumonia
- ☐ More than 6 ear infections in one year
- ☐ Other:

Notes:

Medications Currently taking:

Allergies:

Surgeries: (please list surgery and year of surgery)

Hospitalizations: (where, when, and why)

FAMILY MEDICAL HISTORY:

Please circle the problem if it runs in the family and note who has the problem (by number) in the space below.

- ☐ 1. Alcohol/drug problems
- ☐ 2. Asthma
- ☐ 3. Birth defects
- ☐ 4. Blindness
- ☐ 5. Blood diseases (sickle cell)
- ☐ 6. Cancer
- ☐ 7. Deafness
- ☐ 8. Diabetes
- ☐ 9. Heart disease
- ☐ 10. High blood pressure
- ☐ 11. High cholesterol
- ☐ 12. HIV/AIDS
- ☐ 13. Hyperactivity
- ☐ 14. Learning disabilities
- ☐ 15. Mental Illness
- ☐ 16. Mental retardation
- ☐ 17. Seizures
- ☐ 18. Skin problems
- ☐ 19. Tuberculosis
- ☐ 20. Die younger than 50 years old?
- ☐ 21. Die as an infant?
- ☐ 22. Other diseases?

Notes:

FAMILY SOCIAL HISTORY:

Persons living in child's home:

Relationship to child	Name	Age	Occupation	Last grade completed	If not at home, involved with child? Live where?
Mother					
Father					
Step Mom / Dad					
Step Mom / Dad					
Brother / Sister (full / half)					
Brother / Sister (full / half)					
Brother / Sister (full / half)					
Brother / Sister (full / half)					
Other					
Other					

The child lives in a house / apartment
How old is where the child lives?
Does it have
Smoke detectors? Yes / No
Guns? Yes / No
Pets? Yes / No Kind of pet(s):
Smokers? Yes / No
Well water? Yes / No

Stresses or changes (deaths, divorces, disability)?

Domestic Abuse/Neglect? Yes / No

PERSON COMPLETING FORM: Sign name: **Relation to child:** **Date:**