GFP

GENEVA FAMILY PRACTICE

302 Randall Road * Suite 202 * Geneva, IL 60134 * (630) 232-1818 * Fax (630) 232-1868
www.genevafamilypractice.com * GFP@GFP1.com

NEW PATIENT PEDIATRIC QUESTIONNAIRE

Child's Name: _____ **Birth Date:** _____

MEDICAL HISTORY

- **Place of birth:** _____
- **List any significant problems with pregnancy, labor or delivery, or the first few months of life:**

  _____

  _____
- **List recent health problems:** _____

  _____
- **List all known allergies (foods, pollens, medications) and type of reaction (hives, rash, vomiting):**

  _____

  _____
- **Serious chronic illness or health problems:** _____

  _____
- **Surgeries/Procedures (including circumcision):** _____
- **Medications:** _____
- **Hospitalizations other than birth:** _____
- **Accidents/injuries:** _____
- **Other physicians seen regularly:** _____
- **Are immunizations up-to-date?** _____ **Yes** _____ **No**
- **Has your child been screened for any developmental problems?** ____ **Yes** ___ **No**
- **Has mom had any postpartum depression since having this baby?** ____ **Yes** ___**No**

  If yes, please explain:

  _____

  _____

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CHILD'S SOCIAL HISTORY

- **Please list the name, age and relationship for all persons currently living in your home:**

  _____
  _____
  _____

- **Does your child attend daycare? _____ Yes _____ No**
  If yes, or if planned, what is the facility's name and # of days per week attended?
  _____
- **Parental Occupations:**
  Mother: _____ Father: _____
- **Is your home more than 30 years old? _____Yes _____ No**
  If yes, has the patient been tested for lead? **_____ Yes _____ No**
- **Has your house been tested for radon? _____ Yes _____ No**
- **Does your house have its own well? _____ Yes _____ No**
- **Is your home "child-proofed"? _____ Yes _____ No**
- **Is anyone immunocompromised in your household (cancer, HIV, etc.)? ___ Yes ___ No**
- **Does anyone in your family use any of the following: _____ Yes _____ No**

	Child	Family member	How often?
Cigarettes	_____	_____	_____
Alcohol	_____	_____	_____
Drugs	_____	_____	_____

CHILD/FAMILY MEDICAL HISTORY

	Child	Family member	Relationship (mom, dad, etc.)
Diabetes	___	_____	_____
High Blood Pressure	___	_____	_____
Stroke	___	_____	_____
Heart Disease	___	_____	_____
Cancer	___	_____	_____
Other	___	_____	_____
Other	___	_____	_____