Shifa Pediatric Clinic, PLLC

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Ph: (919) 300-SPC6 (7726), Ph/Fax: (919) 300-7688
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History Questionnaire-New Patient

_______________________________ Form Completed By
_____________________________ Date Completed

Childs Name: ___________________Birth Date:____________ Sex: M/F

Household: Please list all those living in the child's home

Name	Relationship to child	Birth Date	Health Problems

Birth History:

Birth Weight _________________ Birth Hospital/Country if born outside USA: _______________________
Mom's Gestation _______________weeks
Was the delivery Vaginal? Or Cesarean? If cesarean, why? _________________________________
Did mom have any illness or problem with her pregnancy? If yes, explain ___________________
Did baby have any problems right after birth? If yes, explain_______________________________________
Did baby go home with mother from hospital?____________________ If no, explain ______________________
Was initial feeding Breast? Or Bottle?__________________________How long was the child breastfed?_______
During pregnancy did mom Smoke ______ Drink alcohol ______ Use drugs or medications _______________

General:

Do you consider your child to be in good health?__ Yes __No Explain _________________________________
Does your child have any serious illness or medical condition? ___Yes ___No Explain___________________
Has your child had serious injuries or accidents? ___Yes___ No Explain ____________________________________
Has your child had surgery?___ Yes____ No Explain ____
Has your child ever been hospitalized? ___Yes____ No Explain ____
Is your child allergic to any medications or drugs? ___ Yes____ No Explain ______________________________
Is your child allergic to any food product? _____Yes _____No Explain____________________________
Source of Drinking Water: _____City_____Well
Was your child exposed to any known or suspected case of TB:_________________________
Was your child born outside USA:______________
Within the last 1 year did you/your child travel outside the country:____________________________

Development:

Are you concerned about your child's development?_____ Yes____ No Explain_______________________
Are you concerned about your child's mental or emotional development? ____Yes ____No Explain___________
Has he/she failed or repeated a grade in school? _____________________________

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Family History: Have any family members had the following:

Deafness: Yes/No Who _____________ Comments ______________________________________
Nasal Allergies: Yes/ No Who _____________ Comments ______________________________________
Asthma: Yes /No Who _____________ Comments ______________________________________
Tuberculosis: Yes/ No Who _____________ Comments ______________________________________
Heart disease (before age of 50 years) :Yes /No Who _____________ Comments _________________________
High Blood Pressure (before 50 years) : Yes /No Who _____________ Comments _________________________
High Cholesterol: Yes /No Who _____________ Comments ______________________________________
Anemia: Yes/ No Who _____________ Comments ______________________________________
Bleeding Disorder: Yes/ No Who _____________ Comments ______________________________________
Cancer: Yes/No Who________________Comments______________________
Liver Disease: Yes/ No Who _____________ Comments ______________________________________
Kidney Disease: Yes/ No Who _____________ Comments ______________________________________
Diabetes (before 50 years): Yes/ No who _____________ Comments __________________________
Bed-Wetting (after 10 years of age): Yes /No who _____________ Comments ______________________
Epilepsy or Convulsions: Yes/ No Who _____________ Comments ______________________________________
Alcohol Abuse: Yes /No Who _____________ Comments ______________________________________
Drug Abuse: Yes/ No Who _____________ Comments ______________________________________
Mental Illness: Yes/ No Who _____________ Comments ______________________________________
Mental Retardation: Yes/ No Who _____________ Comments ______________________________________
Immune Problems, HIV, or AIDS: Yes/ No Who _____________ Comments _____________________________
Additional family history ____

Past History: Does your child have or has he/she ever had:

Chickenpox ____Yes_____ No When ____
Frequent ear infections ____Yes____ No Explain ____
Problems with ears or hearing____ Yes____ No Explain ____
Nasal Allergies____ Yes____ No Explain ____
Problems with eyes or visions ____Yes____ No Explain ____
Asthma, Bronchitis, Bronchiolitis, or Pneumonia ____Yes____ No Explain ______________________________
Any heart problem or heart murmur____ Yes____ No Explain _______________________________________
Anemia or bleeding problem____ Yes____ No Explain ____
Blood transfusion____ Yes____ No Explain ____
Frequent Abdominal pain____ Yes____ No Explain ____
Constipation requiring doctor visits____ Yes____ No Explain ______________________________________
Bladder or kidney infection____ Yes____ No Explain ____
Bed-Wetting (after 5 years of age)____ Yes____No Explain ___________________________________
(for girls) Has she started her menstrual periods? ____Yes____ No When __________________________
(for girls) Are there any problems with her periods? ____Yes____ No Explain ______________________________
Any chronic or recurrent skin problems ____Yes____ No Explain _______________________________________
Frequent headaches____ Yes_____ No Explain ____
Convulsions or other neurologic problems____ Yes____ No Explain ___________________________________
Diabetes____ Yes____ No Explain ____
Thyroid or other endocrine problems ____Yes____ No Explain _________________________________
Use of alcohol or drugs ____Yes ____No Explain ____
Please mention any other significant information that your health provider should be aware of:
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