

Patient Questionnaire



Patient's Name		Name of Person Completing this Form			
Feeding and Nutrition					
Food Allergies (please list)			Appetite Good?	Y	N
			Feeding Problems in the first 3 months?	Y	N
			Vitamins	Y	N
			Colic in the first 3 mos	Y	N
	Breast Fed	Y	N	# Of Months	
Formula Fed	Y	N	Brand		
Special Diet	Y	N			
If Yes, please explain					

Family Profile			
Mother's Name		Age	
Father's Name		Age	
Please list child's sibilins and ages:		Age	
		Age	
		Age	
		Age	

Family Medical History							
Anemia/Blood Disorder	Y		N	Epilepsy/Seizures	Y		N
Asthma	Y		N	Heart Disease	Y		N
Mental Retardation	Y		N	Drug/Alcohol Problems	Y		N
High Blood Pressure	Y		N	Diabetes	Y		N
Cholesterol Problems	Y		N	Migranes	Y		N
Cancer	Y		N	AIDS/HIV	Y		N
Sudden Infant Death Syndrome	Y		N	Birth Defects	Y		N
Cystic Fibrosis	Y		N	Muscular Dystrophy	Y		N
Tuberculosis	Y		N	Arthritis	Y		N
Depression	Y		N	Psychiatric Problems	Y		N
Does anyone smoke in the home?	Y		N	If yes, who?			

Development and Behavior							
Age When:				Development When Compared to Other Children			
Sat Alone		Walked		<i>circle one</i>	Behind	Similar	Advanced
Toilet Trained		Bicycled		Learning Problems		Y	N
Behavioral Problems	Y		N	If Yes, please explain			
If Yes, please explain							
Bedwetting Problems	Y		N	List Your Child's Hobbies/Sports/Social Activities:			
If Yes, please explain							
Daycare/Preschool	Y		N	By signing below, I agree that I have filled out this form truthfully and to the best of my knowledge			
If Yes, please list name and days attending							
If no, who is responsible for care of your child during the day? (please list names & relation)							
				Signed:		Date:	
				Received by:		Date:	