BAER PEDIATRICS LLC

New Patient Questionnaire

Date: _____

NAME: _____ **DOB:** _____

Parent/Guardian Name(s): _____

Parents are: □ Single □ Married □ Divorced □ Widowed

Child lives with: _____

Do you have any pets? □ No □ Yes _____

Birth History:

Any pregnancy complications? □ No □ Yes

If yes, explain _____

Route of Delivery: □ Vaginal □ C-Section Reason:_____

Birth Weight: _____

Any complications after birth? (Difficulty breathing, jaundice) □ No □ Yes

If yes, explain _____

Medications: (please list all, including vitamins, supplements, etc.):

_____

_____

Allergies: (medications, foods, insect bites, environmental):

_____

_____

Immunizations: (please circle one) UP TO DATE NOT UP TO DATE

Hospitalizations/Surgeries: (please include reason and date)

_____

_____

Chronic Problems: (check all that apply)

□ Abdominal Pain
□ Academic Difficulty
□ Acid Reflux (GERD)
□ Acne
□ ADD or ADHD
□ Allergies
□ Asthma
□ Bedwetting
□ Behavior Problems
□ Constipation
□ Eczema
□ Growth Problems
□ Headaches
□ High Blood Pressure
□ Obesity
□ Sleep Disturbance
□ Other: _____
_____

Family History: Please list conditions any parents or siblings have experienced or take medication for

_____

_____

Please indicate if your child:

Has second-hand smoke exposure? □ No □ Yes

Resides in/spends frequent time in a home built before 1978? □ No □ Yes

Drinks well water? □ No □ Yes

Please list any other information you think your pediatrician should know about your child's health:

_____

_____

_____ _____

Parent/Guardian Signature Date .