



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)

- | | | |
|--|--|--|
| <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Asthma | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Academic Difficulty | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Acid Reflux (GERD) | <input type="checkbox"/> Behavior Problems | <input type="checkbox"/> Obesity |
| <input type="checkbox"/> Acne | <input type="checkbox"/> Constipation | <input type="checkbox"/> Sleep Disturbance |
| <input type="checkbox"/> ADD or ADHD | <input type="checkbox"/> Eczema | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Growth Problems | _____ |

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