Alan D. Glassman, M.D., P.C.

Pediatric and Adolescent Medicine

700 Sunset Drive, Suite 504
Athens, Georgia 30606

Telephone: (706) 549-3943
Fax: (706) 549-4132

NEW PATIENT QUESTIONNAIRE

Patient's Name ______________________ DOB: ____________ Today's Date ________

Mother's Name ______________________ Age ___ Father's Name ______________________ Age ___

PREGNANCY AND BIRTH

Mother's age at child's birth ____________
What number pregnancy was this child? ________
Did mother have any illness during pregnancy? Y N

Did she take any medications other than vitamins and iron? Y N
If yes, what? ____________________

Was the baby on time? Y N
If no, how early was your baby? ____________

Were there any complications with the baby during delivery? Y N

____

Was the delivery **vaginal** or by **C-section**? (circle one)

Did the baby go home at the same time as mom? Y N

Did the baby have any trouble while in the hospital? (Jaundice, Infections, other?) Y N
What kind?

____

Did the baby go to the NICU? Y N

If yes, please give a brief synopsis of the course:

If so, how long were they there? _______

If on ventilator, how long? _______

If on oxygen, how long? _______

Other info (infections, surgeries, interventions) while in NICU:

____
____
____
____
____

Birth Weight __________ Birth Length __________

Are your child's vaccinations up to date? Y N
If not, Why? ____________________

____

FEEDING AND NUTRITION

Is your child's appetite usually good? Y N

Was there severe colic or any unusual feeding problems during the first 3 months? Y N

Do any foods disagree with him/her? Y N
If so, what? ____________________

For the first 6 months, is he/she (was he/she) breast-fed or bottle-fed? ____________________

If still on formula, which one? ____________

Does he/she take vitamins? Y N

DEVELOPMENT/BEHAVIOR

At what age did child sit alone? ____________

At what age did child walk alone? ____________

Did child say any words by the time he/she was 1 ½ years old? Y N

How does child compare to others of same age?

____

Does child have any trouble sleeping? Y N

What grade is the child in? ____________

Has child had any trouble in school? Y N

Does child get along with other children? Y N

Does child haven any of the following? (circle all that apply)

Thumb sucking	Nail biting
Bed wetting	Bad temper
Problems with toilet training	Hyperactivity
Problems with discipline	Nightmares
Speech problems	Other

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Has your child had any of the following medical problems? Please circle

Serious injuries or accidents	Surgeries
Hospitalizations	Chickenpox disease
Frequent ear infections	Hearing loss
Heart problem or murmur	Anemia or bleeding problem
Blood transfusion	Frequent abdominal pain
Bladder or kidney infection	Kidney problem
Bedwetting (after 6 years of age)	Eczema
Use of alcohol or drugs	Learning disorder

Constipation requiring Dr Visits

Asthma/wheezing/pneumonia

Allergies-seasonal, animals, indoor, foods ·

Allergic reactions - medications, vaccinations

Frequent headaches

Convulsions or other neurologic problems

Diabetes/blood sugar problems

Thyroid or other endocrine problems

Other significant problem

PAST MEDICAL HISTORY

Where has your child gone for check-ups until now?________________________

Date of last check-up? ____________________

Date of last dental check-up? ____________________

Are any medications taken regularly? Y N
Please list names, dosages and frequency taken?

____
____
____
____
____
____
____

If female, have periods started? Y N

When? ________________________

If female, any problems with periods?

____
____
____
____

SAFETY/ENVIRONMENT

Do you live in a: (please circle)

Private home Apartment

Mobile home Other: ______

Day Care? ______________ Sitter? ______________

Do you know the hottest temperature of the water in your pipes? Y N

Is there a working smoke alarm on each floor in the house? Y N

Does your child always use a car seat/seat belt when riding in the care? Y N

Are there any smokers in the household? Y N

Are there any problems with the condition of your home (peeling paint, insects, rats or mice)? Y N

Are there any guns in the house? Y N

Are there any pets in the house? Y N

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FAMILY HISTORY

(Mark if present in any of your child's siblings, aunts/uncles, first cousins or grandparents)

Spina Bifida

Bone disorder

Cleft lip/palate

Hearing loss/deafness

Heart disease/defect

Neurofibromatosis

Mental retardation

Neurological disorder

Mental Illness

Tuberculosis

Hay fever/allergies

Sickle Cell Anemia

Muscle disorder

Skin disease

High blood pressure

Urinary tract abnormality

vision/eye problems

cerebral Palsy

ADD/learning disorder

Convulsions

Infertility

Limb defects

Down Syndrome

Cystic fibrosis

Short stature (<5ft)

Diabetes

Drug/alcohol problems

Bleeding disorder

Kidney disease

Genital abnormality

Asthma

AIDS (HIV)

High cholesterol/triglycerides

Chromosome abnormality

Brain anomalies (includes Hydrocephaly)

Anemia (includes Thalassemia)

Patient's mother was exposed to DES

Other birth defect/malformations/problems?

Please list: ______________________________

____

List age, sex, and health problems of brothers and sisters (are they living?) ______________________________

____