New Patient Questionnaire for Baylor Scott & White Pediatrics Las Colinas

Name_____Birthdate_____

Mother's Name_____Age____Occupation_____

Father's Name_____Age____Occupation_____

Birth History:

Gestation (was the baby on time?)_____Birthweight_____

Complications while at hospital (jaundice, infection, other) _____

Past Medical History:

Allergic reactions to medications/foods/insect bites? _____

Reactions to immunizations? Which ones? _____

Hospitalizations other than birth? _____

Any serious injuries? _____

Any surgeries? _____

Any medications taken regularly? _____

Has the child been treated for or diagnosed with any of the following:

Allergies……...Yes or No
Asthma……Yes or No
Frequent ear infections……Yes or No
Eye problems……...Yes or No
Hearing problems……Yes or No
Frequent colds, pneumonia, cough……Yes or No
Heart problems or murmur……..Yes or No
Problems with urination……..Yes or No
Seizers/convulsions…….Yes or No
Skin conditions……Yes or No
Other: _____

Family History:

Circle any diseases that the child's parents, grandparents, brothers, sisters, aunts and uncles have had. If yes, please list which relation:

	Relation		Relation
Anemia…….. Yes or No	_____	High Blood Pressure.. Yes or No	_____
Asthma…….. Yes or No	_____	High Cholesterol…… Yes or No	_____
Allergies…… Yes or No	_____	Mental Illness…….Yes or No	_____
Cystic Fibrosis……Yes or No	_____	Seizures…….. Yes or No	_____
Cancer ……Yes or No	_____	Sickle Cell……. Yes or No	_____
Diabetes……..Yes or No	_____	Thyroid Problem…… Yes or No	_____
Eczema……Yes or No	_____	Tuberculosis…….. Yes or No	_____
Heart Problems……Yes or No	_____	Other…….. Yes or No	_____

Have any of your children died? ……Yes or No

Pharmacy name: _____ Pharmacy address: _____

Updated 6/23/2020-kw