NEW PATIENT HISTORY QUESTIONNAIRE

Please complete this entire questionnaire as best you can and hand this completed packet to the Medical Assistant when you are called back. This packet will inform us of the patient's history and will help us to treat them in the best way possible. Thank you!

TODAY'S DATE: ______________________________

PATIENT'S NAME: ______________________________

DATE OF BIRTH: ______________________________

PATIENT'S PRIMARY PHYSICIAN: ______________________________

SUBSPECIALIST PHYSICIANS: ______________________________

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WHAT IS THE REASON THE PATIENT WAS REFERRED TO US?

____

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MEDICATIONS

Please list all medications the patient is currently on including their dosage amount, how many times it is used, and approximately when the medicine was first prescribed.

Name of Medication	Dose (leave blank if unsure)	How often per day (or if not using regularly write "sometimes")	Approximately when medication was first prescribed
Example: Flovent	***40mcg, 2 sprays***	***Every 4 hours as needed***	***June 2003***

ANY DRUG ALLERGIES: ☐ YES ☐ NO

If yes, list drugs and reaction: ____________________________________

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IMMUNIZATIONS

Are the patient's immunizations up to date? ☐ YES ☐ NO

If no, which immunizations have they not received and why?

____

Did the patient receive the flu shot in the past 12 months? ☐ YES ☐ NO

Any past allergic reaction to the flu shot? ☐ YES ☐ NO

ALLERGIES

Does the patient have any food allergies? ☐ YES ☐ NO

If ***yes***, to what and what is their reaction? (*e.g. peanuts – hives)*

____

Does the patient have any seasonal or pet allergies? ☐ YES ☐ NO

If ***yes***, to what and what is their reaction? (*e.g. cats – runny nose and itchy eyes)*

____

Has the patient ever had any skin or allergy testing (skin or blood test)? ☐ YES ☐ NO

DIET

Is the patient on any special diet? ☐ YES ☐ NO

If ***yes***, what? ____

If patient is an infant, on average, how many ounces per feed (if breastfeeding, how long) and how many feeds per 24 hours? *(e.g. 3 oz., 8 feeds per 24 hours)*

____

If patient is on G-tube feed, what is it, how much do you give, when do you give it, and over how long? *(e.g. Peptamen Jr., 1 can bolus 3 times per day + 3 cans over 8 hours at night)*

____

BIRTH HISTORY

Was the patient born on time? ☐ YES ☐ NO

If ***no***, what was the patient's gestational age? ______________________________

What was the patient's birth weight? ______________________________

Was the patient delivered vaginally or via cesarean section? If *cesarean section*, why?

____

Did the patient experience any complications upon birth? ☐ YES ☐ NO

If ***yes***, what kind? ______________________________

How long did the patient need to stay in the hospital when they were born? ____________

Did they have to stay in the Neonatal Intensive Care Unit (NICU)? ☐ YES ☐ NO

HOSPITALIZATIONS

Has the patient ever been hospitalized? ☐ YES ☐ NO

Has the patient ever had to go to the Emergency Room? ☐ YES ☐ NO

Has the patient ever had any surgeries? ☐ YES ☐ NO

If ***yes*** to any of the above questions, please specify what type of visit, date, and reason for visit below:

Type of visit (i.e. ER, Hospital, Surgery)	**Date**	**Reason for visit**

FAMILY HISTORY

Does anyone in the patient's biological family have (up to the patient's grandparents):			If ***yes***, what is their relation to the patient? *(e.g. maternal aunt, paternal grandfather)* *Note: Maternal = mother's, Paternal = father's*
Allergy runny nose, hay fever, or seasonal allergies	☐ YES	☐ NO	
Asthma	☐ YES	☐ NO	
Childhood deaths	☐ YES	☐ NO	
Cystic Fibrosis	☐ YES	☐ NO	
Eczema	☐ YES	☐ NO	
Immune system problems (e.g. recurrent pneumonia, recurrent skin infections, HIV)	☐ YES	☐ NO	
Sickle cell disease	☐ YES	☐ NO	
Sudden unexpected infant death	☐ YES	☐ NO	
Tuberculosis	☐ YES	☐ NO	

SOCIAL HISTORY

Please list ALL family members the patient currently lives with:

(e.g. mom, dad, 2 sisters, cousins, grandparents)

____

Are there any inside/outside pets present? ☐ YES ☐ NO If *yes*, what?__________

Does anyone smoke inside/outside the house? ☐ YES ☐ NO If *yes*, who?___________

Has the patient traveled out of Nevada in the past 6 months? ☐ YES ☐ NO

If ***yes***, where? ____

If school-aged, what grade is the patient in? ___________________________________

If too young for school, does the child attend daycare or stay with a babysitter? ☐ YES ☐ NO

Does the patient play any sports? If ***yes***, what sport(s)? ______________________________

Please go through the following list and note which symptoms the patient has:

Symptoms	*YES*	*NO*
Fever in the past 7 days?		
Weight loss or poor weight gain?		
Poor energy?		
Frequent itchy eyes?		
Frequent runny nose or nasal congestion?		
Episodes of turning blue in the face (e.g. lips, tongue)?		
Frequent chest pain?		
Easily fatigues with exercise?		
Shortness of breath?		
Working hard to breathe (e.g. chest retractions or deep sucking in of the skin in or around the bones of the chest)?		
Frequent noisy breathing?		
Wheezing or whistling sound coming from their chest?		
Frequent coughing during the day?		
Frequent coughing while asleep?		
Frequent chest pains, heartburn, sour taste in mouth, spit-ups, or pain/fussiness within 30 -60 minutes after eating?		
Diarrhea?		
Stools that appear greasy/oily or typically float rather than sink?		
Frequent coughing or choking while eating/drinking?		
Snoring?		
Gasping for air while asleep?		
Progressive weakness of muscles?		
Frequent headaches?		
Blood colored urine?		
Swelling of face, arms, or legs?		
Easy bruising of skin?		
Bleeds with brushing teeth or prolonged bleeding with cuts?		
Joint swelling or redness or pain?		
Rashes?		
Depression or suicidal thoughts?		