NEW PATIENT QUESTIONAIRE

Patient Name:_____ **Date**: _____

Primary Care Physician: _____

Did a Physician refer you? Yes □/No□ If "yes:" Referring Physician: _____
If referral is other than a physician, please indicate: Friend □/Family □/Internet□/Lactation Consultant□/
Other_____

What is the reason for your visit today?_____
How long has this been a problem? Since birth□/Other_____. Is it getting worse? Yes □/ No□

Pregnancy History:

How many pregnancies has mother had? _____
How many pregnancies delivered after 37 weeks? _____
How many pregnancies delivered before 37 weeks? _____
How many pregnancies did not result in a live birth? _____

Birth History:

What week was baby born? _____*weeks,* _____*days*
*Baby's birth weight:*_____ *lbs* _____ *oz*
Baby's birth length: _____ *in*
How long until baby regained birth weight? _____
Delivered: C-section □/ Vaginal □
*Was birth assisted by: induction (pitocin/cytotec) □/ forceps □/ vacuum □/ other*_____
*How long was labor?*_____
*How long was baby in the pelvis?*_____
*Any complications with the pregnancy?*_____
_____
*Any complications with delivery?*_____
_____

Does baby turn his/her head well to the right? Yes □/ No□ and to the left? Yes □/ No□
How long does baby sleep at night?_____
What is baby's primary source of food? Breast-fed □/ Bottle-fed formula □/ Bottle-fed breast milk □/ Other:_____
When feeding, how long does baby latch?_____ or how many oz consumed per feeding?_____

BABY'S MEDICAL HISTORY - Please list all medical diagnoses (if any): None □

_____
_____
_____

SURGICAL HISTORY (if any): None □ **DATE**

1. _____ _____
2. _____ _____
3. _____ _____
4. _____ _____

FAMILY HISTORY

Please list any known medical problems:

Father: _____

Mother: _____

Siblings: _____

SOCIAL HISTORY

What family members does baby live with? Mother □/Father □/Siblings □ how many? ____/Other:_____

Does anyone in the home smoke? Yes □/No□

Are there pets in the home? Yes □/No□ *If yes, what animal(s):*_____

REVIEW OF SYSTEMS

Please circle any of the following problems that you observe in baby:

Constitutional: weakness, fatigue, fever

Eyes: eye discharge, eye redness, tearing

Ear, Nose, Throat: nasal congestion, sore throat

Cardiovascular: shortness of breath, ankle swelling

Respiratory: cough, sputum, coughing up of blood, difficulty breathing, wheezing

Gastrointestinal: excessive spitting up, vomiting, abdominal pain, constipation, diarrhea, bowel incontinence, bloody stool

Genitourinary: pain with urination, bladder incontinence, blood in urine

Musculoskeletal: pain with movement, stiffness

Skin: rash, lumps, itching, hair changes, nail changes

Neurological: weakness, numbness, seizures, blackouts

Psychological: nervousness, tension/anxiety

Endocrine: heat or cold intolerance, sweating, thirst, hunger

Hematologic: easy bruising, easy bleeding

MEDICATIONS

Please list all prescription and non-prescription medications, vitamins and supplements baby is currently taking (including dosage, frequency and indication):

1._____ 2._____ 3. _____

ALLERGIES

*Allergies and intolerances:(including antibiotics, local anesthetics, x-ray contrast dyes, or latex materials, shellfish, aspirin products, foods etc..)*_____

I, the undersigned, have completed these forms to the best of knowledge. The information that I have provided is true and accurate to the best of my knowledge.

_____ _____

Patient/Guardian Signature Date

_____ _____

Physician Signature Date