NEW PATIENT PAEDIATRIC QUESTIONNAIRE

What problem/s is your child experiencing?

____

____

History of present illness

Please describe the location of your child's problem:

____

How long have the symptoms been present (mths/years):__________________________

List any MEDICAL problems (diabetes, cancer, infections, etc) your child has had in the past, including the dates, if possible:

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

□ None

List any SURGERIES that your child has had in the past, including dates, if possible:

______________________________ ____________

______________________________ ____________

______________________________ ____________

______________________________ ____________

□ None

List current medications:

Name Dose Per day

____

____

____

____

____

□ Nil medications

Additional Specialists (Pediatrician, Audiologist, Speech therapist, Respiratory, Endocrinologist, etc):

Name

____

____

____

□ None

PATIENT LABEL
Name:
DOB:

Do your child have any drug/medication allergies?

☐ Yes ☐ No

If Yes, please list below:

____

____

____

Does your child have asthma? ☐ Yes ☐ No

Inhalers usage?:

☐ Regular use ☐ intermittent only ☐ I don't use

Do any diseases or cancers run in your family? Please list:

____

____

Immunisation track

Are immunisations up to date ☐ Yes ☐ No

Social History

School year: ______________________________

Does your child:

Snore? ☐ Yes ☐ No

Have speech/language delays? ☐ Yes ☐ No

Have behavioral issues? ☐ Yes ☐ No

Guardian/Parent: .... Date ....