NEW PATIENT QUESTIONNAIRE

pure**PEDIATRICS**

Alana A. Kennedy-Nasser, MD
6750 West Loop South, Suite 465
Bellaire, TX 77401
Office: (832) 431-4336
Fax: (832) 460-6399

Patient Name: ____ Nickname: ____________________________
Last First Middle

Address: ____ Phone: ________________________________
City Zip

Date of Birth: ______/______/______ Age: ________ SSN: ______/______/______ Sex: __________________________

Mother's Name: ____ Cell: ________________________________

Mother's Occupation: __________________________ Mother's Email: ______________________________________

Father's Name: ____ Cell: _________________________________

Father's Occupation: __________________________ Father's Email: ______________________________________

How did you hear about us? ____

Current Pediatrician: ____

Current Subspecialists: ____

Preferred Hospital: ____

Preferred Pharmacy: ____

IF YOU HAVE MORE THAN ONE CHILD, PLEASE FEEL FREE TO ONLY NOTE THE PERTINENT PATIENT INFORMATION ON SUBEQUENT FORMS.

BIRTH HISTORY

Birth weight: ______________________ Length? ____________________ Full-term? ____________________________________

Type of Delivery (**CIRCLE ONE**): VAGINAL C-SECTION VBAC FORCEPS SUCTION

Complications during pregnancy? ____

Complications after birth? ____

How long did baby stay in hospital? ____

Breast or bottle fed? ____

MEDICATIONS/IMMUNIZATIONS

Please list any medicines and doses: ____

Is your child allergic to any medicines, food or substances? ____

If yes, please describe the allergy: ____

Does your child receive a yearly flu vaccine? ____________ Are vaccines up to date? ____________________________________

Please send a copy of immunization record to our office at your next appointment or fax to 832-460-6399.

PAST MEDICAL HISTORY

Has your child suffered any of the following? **PLEASE CIRCLE.**

ASTHMA	EAR INFECTIONS	KIDNEY PROBLEMS
PNEUMONIA	THYROID PROBLEMS	DIABETES
BRONCHITIS	THROAT INFECTIONS	SKIN ISSUES/RASHES
ALLERGIES	HEART PROBLEMS	BLEEDING DISORDER
SINUS PROBLEMS	IRRITABLE BOWEL	ANEMIA
BREATHING DIFFICULTIES	CONSTIPATION	SPEECH DELAY
SNORING	CHRONIC DIARRHEA	DEVELOPMENT DELAY
VISION PROBLEMS	URINARY INFECTIONS	OTHER ______________________
HEADACHES	HEAVY MENSES	____________________________

Hospitalizations: ____________________

ER visits: ____________________

Surgeries: ____________________

FAMILY HISTORY

Please note if anyone in your immediate family has suffered the following. **PLEASE CIRCLE.**

HIGH BLOOD PRESSURE	THYROID DISEASE	MENTAL ILLNESS
HEART ATTACKS	SICKLE CELL DISEASE	BIRTH DEFECTS
STROKES	ANEMIA	MISCARRIAGES
HIGH CHOLESTEROL	BLEEDING DISORDERS	HEAVY MENSES
DIABETES	MUSCULAR DISORDERS	SHINGLES
COPD OR EMPHYSEMA	LIVER DISEASE	DEVELOPMENT DELAY
ASTHMA	ALCOHOL ABUSE	OTHER ____________
LUNG DISEASE	SUBSTANCE ABUSE	____________
CANCER	TOBACCO USERS	____________

Anyone in the extended family die before age 50? ____________________

Anyone with cancer at a young age? ____________________

SOCIAL HISTORY

Who does your child live with? ____________________

Names and ages of any siblings: ____________________

What sports does your child play? ____________________

Favorite hobbies? ____________________

Extracurricular activities? ____________________

Learning difficulties? ____________________

Name of School: ____________________ Grade: ____________