



Medical Home for Children

NEW PATIENT QUESTIONNAIRE

PLEASE FAX THIS 3 PAGE FORM TO 914-594-3693 OR MAIL TO ADDRESS BELOW

Patient Name: _____ Patient Date of Birth: _____ Sex: M or F

Parent/Guardian Information	
Name:	Home Phone:
Address:	Work Phone:
	Cell Phone:
	Other Phone:

Pediatrician Name: _____ Phone Number: _____

Who referred your child to Medical Home? _____

Please list your child's medical conditions

- | | |
|-----------------------------|-----------------------------|
| 1. _____ Age of onset _____ | 4. _____ Age of onset _____ |
| 2. _____ Age of onset _____ | 5. _____ Age of onset _____ |
| 3. _____ Age of onset _____ | |

In addition to your Pediatrician, please list the other doctors who care for or have cared for your child

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Name: _____ Specialty: _____ Phone #: _____

Birth History / Pregnancy

Age of mother at delivery: _____ Illnesses in mother/pregnancy complications: _____

Medications taken during pregnancy? _____

Any abnormalities noted on screening tests (ultrasound, amniocentesis or blood tests)? No Yes: _____

Delivery

_____ Vaginal _____ C-Section – Reason? _____ Hospital: _____

Full Term: Yes No - If No, # of weeks early? _____ Birth Weight: _____

Complications: _____

NICU Care: No Yes – If Yes, how long? _____

Medical History

Does your child take medication on a regular basis? No Yes (If Yes, list below)

1. _____ 3. _____

2. _____ 4. _____

Is your child allergic to any drugs or medications? No Yes (If Yes, list drug and reaction)

1. _____ 3. _____

2. _____ 4. _____

Has your child ever been hospitalized? _____ No _____ Yes (If Yes, describe below)

	Age	Hospital	Problem(s)
1.			
2.			
3.			
4.			
5.			

Development

Does your child have a developmental disability? _____ No _____ Yes

Does your child receive any of the following services?

- | | | |
|----------------------------|------------------------|------------------------------------|
| _____ Physical Therapy | _____ WIC | _____ Special Education |
| _____ Occupational Therapy | _____ SSI | _____ Special Transportation Needs |
| _____ Speech Therapy | _____ Mental Health | _____ Other _____ |
| _____ Early Intervention | _____ Family Resources | |

Does your child receive home care? ___ No ___ Yes (If Yes, describe below)

Home Care Agency _____
 Coordinator's Name _____ Phone Number _____
 Services Provided _____

Does your child use durable medical equipment? _____ No _____ Yes (If Yes, describe below)

Company Name _____ Phone Number _____
 Supplies Provided _____

Does your child attend school? _____ No _____ Yes (If YES, Grade and Location) _____

Diet

Does your child have any food allergies? _____ No _____ Yes (If Yes, list below)

1. _____ 3. _____
 2. _____

Does your child have any dietary restrictions or require a special diet? ___ No ___ Yes (If Yes, list below)

1. _____ 3. _____
 2. _____

Does your child take any nutritional supplements? _____ No _____ Yes (If Yes, list below)

1. _____ 2. _____

Home Life

Who lives in the home with your child?

Primary Care Taker / Relationship to child _____

Mother's occupation _____

Father's occupation _____

Marital status _____ Married _____ Single _____ Separated _____ Divorced

If divorced, who has custody? _____

Does anyone in the child's home smoke? _____ No _____ Yes (If Yes, who? _____)

Are there any pets in the child's home? _____ No _____ Yes (If Yes, list) _____

Family Medical History

Has anyone in your child's family been diagnosed with any of the following conditions? (Check all that apply)

	Mother	Father	Sibling	Other		Mother	Father	Sibling	Other
Alcoholism					Hearing Loss				
Allergies					Heart Attack before age 50				
Anemia					Heart Defect from Birth				
Anxiety					High Blood Pressure				
ADHD					High Cholesterol				
Asthma					Lead Poisoning				
Autism					Learning Problems				
Bedwetting					Mental Retardation				
Birth Defects					Metabolic Disease				
Bleeding Disorder					Migraine Headaches				
Cancer					Obesity / Overweight				
Cystic Fibrosis					Obsessive Compulsive Disorder				
Depression					Sickle Cell Disease				
Diabetes					Schizophrenia				
Eating Disorder					Seizures				
Eczema					Tuberculosis				
Genetic Abnormality					Other				

Parent / Guardian's Signature _____

Date _____

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