McKenzie Pediatrics
New Patient Health Questionnaire

Welcome to our office! Please take the time to complete this short questionnaire in order to assist us in providing the best care possible for your child. Thanks!

Child's Name: _________________________ Child's Date of Birth: ____________________

Today's Date: _________________________

Birth History:

1. Was your child born full-term (37 weeks or greater)? Yes No (if not, when: _____________________)
2. Did you have any complications to your pregnancy? No Yes
   If yes, please describe: ____
3. Were there any complications to your delivery? No Yes
   If yes, please describe: ____
4. What was your baby's birth weight? ________lbs________ounces
5. Did your baby go home with you? Yes No
   If not, why not? ____

Siblings:

Please list all of your child's siblings:
________________________________Birthdate___________________
________________________________Birthdate___________________
________________________________Birthdate___________________
________________________________Birthdate___________________

Family History:

Please circle if any family history of:

juvenile diabetes	birth defects	ADD/hyperactivity
cystic fibrosis	mental retardation	drug dependency
heart disease	childhood cancers	epilepsy/seizures
tuberculosis	sickle cell anemia	anemia/"low blood"
bleeding disorders	asthma	hayfever
eczema	depression	dyslexia

Please mention any other important family history: ____

Lead Risk Factors:

Please circle if can be answered "yes":

1. Has child lived or spent significant time in, now or past, any home built before 1960 undergoing renovation?
2. Has child lived or spent significant time in, now or past, any home with peeling paint (walls, sills, or exterior)?
3. Do any of the child's caregivers have hobbies such as lead jewelry, battery repair, home car repair, ceramics, stained glass, welding?
4. Has child lived, now or past, near any major highway, smelter, or battery factory?
5. Does child exhibit "pica", the eating of dirt or rocks?
6. Does child have sibling or playmate with blood lead level above 20?

Tuberculosis Risk Factors:

Please circle if can be answered "yes":

1. Has child been exposed to anyone with known TB?
2. Has child lived with, or spent significant time with anyone who has recently immigrated from a "3rd-World" country?
3. Has child himself/herself recently immigrated from, or traveled to a "3rd-World" country?
4. Has child lived with, or spent significant time with anyone who has been incarcerated, homeless, an IV drug abuser, or who has HIV?

(please continue to complete other side)

Cholesterol Risk Factors:

Please circle if can be answered "yes":

1. Does child have parent or grandparent who died of a heart attack or stroke before age 50?
2. Does child have parent with serum cholesterol level above 240?

Vaccine Risk Factors:

Please circle if can be answered "yes". Please remember that only **certain** vaccines can't be given if one or several of these risk factors are positive. **Most** vaccines can be safely administered under virtually **any** circumstance. Thanks!

1. Is anyone currently pregnant with close contact to your child?
2. Is anyone currently HIV (+) with close contact to our child?
3. Does anyone currently suffer from cancer, and on chemo- or radiation therapy, with close contact to your child?
4. Is anyone currently on immunosuppressive drugs (such as oral steroids/Prednisone, cytoxan/Imuran, or methotrexate) with close contact to your child?
5. Does your child suffer from any known immunodeficiency, cancer, AIDS, or rheumatoid disease?
6. Has your child ever had any severe, life-threatening reaction to any vaccine? Please note: ________________________

Development and School Performance Questions: (Complete Only Relevant Questions)

1. **Do you have any concerns about your child's learning or school performance?** No Yes
   Explain: ____

2. **Do you have any concerns about your child's attention, concentration, and/or overactivity?** No Yes
   Explain: ____

3. **Do you have any concerns about your child is doing in certain subjects at school?** No Yes
   Explain: ____

4. **Do you have any concerns about how much your child is enjoying school compared to his/her friends or classmates?** No Yes
   Explain: ____

5. **Does your child have any problems completing his/her homework?** No Yes
   Explain: ____

6. **Do you have any concerns about your young child's development?** No Yes
   Explain: ____

7. **Do you have any concerns about your young child's social skills?** No Yes
   Explain: ____

For Moms Only:

1. **Have you been hit, kicked, punched, threatened or otherwise hurt by someone within the past year?**
   No Yes Explain: ____

2. **Do you feel safe in your current relationship?** No Yes
   Explain: ____

3. **Is there a partner from a previous relationship who is making you feel unsafe now?** No Yes
   Explain: ____

Thank you for taking the time to complete this questionnaire. It will greatly assist us in providing the best care possible for your child! –Drs. Huffman, Grenier, and Hokari