PHOENIX CHILDREN'S *Medical Group*

# CARE NEW PATIENT QUESTIONNAIRE

Apply Patient Label

**We look forward to being a partner in your child or teen's care. Please fill out this form to help us get to know you and your child/teen better. The information you give us is private and confidential. You may complete this form before you come or at the time of the visit.**

**What is the most important concern you want to talk about at your first clinic visit?**

_____

_____

_____

| **FAMILY HISTORY** | | |
|---|---|---|
| **Do any of your child/teen's immediate family members (mother, father, brother, sister, grandparents, aunts, uncles) have/had any of the following? Check all that apply.** | | |
| Type 1 Diabetes | ❑ Yes ❑ No | If yes, who: |
| Type 2 Diabetes | ❑ Yes ❑ No | If yes, who: |
| Thyroid Disorder | ❑ Yes ❑ No | If yes, who: |
| Heart attack or Stroke before 55years old | ❑ Yes ❑ No | If yes, who: |
| High Cholesterol | ❑ Yes ❑ No | If yes, who: |
| High Blood Pressure | ❑ Yes ❑ No | If yes, who: |
| Liver Disease | ❑ Yes ❑ No | If yes, who: |
| Obstructive Sleep Apnea | ❑ Yes ❑ No | If yes, who: |
| | | |

| **HOUSEHOLD INFORMATION** | |
|---|---|
| **Are biological parents** | ☐ Married? ☐ Divorced? ☐ Separated? ☐ Single Parent? |
| **Who lives with the child/teen?** | |
| **Number of siblings:** | |

| **SCHOOL INFORMATION** |
|---|
| **Current Grade:** |
| **School Performance:** ❑ Above Average ❑ Average ❑ Learning Resources ❑ Special Education |
| |

| **PREGNANCY/ BIRTH HISTORY** | | |
|---|---|---|
| **Patient Birth Weight:** | **Birth Length:** | |
| **Length of pregnancy (# of weeks)** | | |
| **Did Mom have any illnesses during pregnancy?** | ❑ Yes ❑ No | **Comments:** |
| **Did Mom have diabetes during pregnancy?** | ❑ Yes ❑ No | |
| If yes, did it go away after pregnancy? | ❑ Yes ❑ No | |

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## CHILD/TEEN HOSPITALIZATIONS AND SURGERIES

**Has child/teen been hospitalized or had any surgeries?** ☐ Yes ☐ No
If yes, please list reasons for hospitalization and/or surgery and the date(s).

| Hospitalization/Surgery | Date |
|---|---|
| | |
| | |
| | |
| | |

| Has your child had any of the following symptoms that interfered with daily activities? Check all that apply. | |
|---|---|
| Constitutional | ❑ Weight Loss ❑ Weight Gain ❑ Fever ❑ Illness ❑ Very Tired ❑ Sleep Disturbances |
| Endocrine | ❑ Very Thirsty ❑ Urinating Large Amounts ❑ Very Hungry ❑ Very Tired ❑ Feeling Hot ❑ Feeling Cold ❑ Unusual Body Odor ❑ Period Before Age 9 |
| Dermatological | ❑ Rash ❑ Loss of Hair ❑ Change in Skin Color ❑ Stretch Marks |
| Ear/Nose/Throat | ❑ Sore Throat ❑ Nasal Discharge ❑ Hearing Loss |
| Vision | ❑ Eye Problems ❑ Vision Problems |
| Respiratory | ❑ Cough ❑ Shortness of Breath ❑ Snoring |
| Cardiovascular | ❑ Heart flutter ❑ Chest Pain |
| Gastrointestinal | ❑ Diarrhea ❑ Constipation ❑ Vomiting ❑ Abdominal Pain |
| Neurological | ❑ Frequent Headaches ❑ Seizures |
| Psychiatric | ❑ Anxiety ❑ Depression ❑ Change in behavior ❑ Hyperactive behavior ❑ Easily Distracted |
| Genitourinary | ❑ Urinating often ❑ Nighttime bedwetting ❑ Painful urination |
| Musculoskeletal | ❑ Muscle Pain ❑ Joint Pain ❑ Back Pain |
| Hematological | ❑ Unexplained Bruising |
| Immunological | ❑ Allergic Reaction |
| None | ❑ None of the Above Apply |

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| CIRCLE THE NUMBER THAT BEST DESCRIBES THE PATIENT'S LIFESTYLE CHOICES | | | | | |
|---|---|---|---|---|---|
| Servings per day of fruit and veggies | 1 | 2 | 3 | 4 | 5+ |
| Hours per day of screen time: TV, video games, computer or phone time | 0 | 1 | 2 | 3 | 4+ |
| Hours per day of play/exercise to the point of breathing hard | 0 | .5 | 1 | 2 | 3+ |
| Days per week being active together as a family | 0 | 1 | 2 | 3 | 4+ |
| Glasses (8oz.) per day of sugary drinks (juice, soda, sports drinks, energy drinks, flavored milk, lemonade, kool aid, sweet tea/coffee) | 0 | 1 | 2 | 3 | 4+ |
| Meals per week together as a family | 0-1 | 2 | 3 | 4 | 5+ |
| Days per week eating breakfast | 0-1 | 2 | 3 | 4 | 5+ |
| Hours per night sleeping | <6 | 7 | 8 | 9 | 10+ |

| **MENSTRUAL HISTORY** (Girls only) | |
|---|---|
| **Has your child ever had a menstrual period?** If yes, what age did they start? | ❑ Yes ❑ No |
| **Do periods occur regularly?** | ❑ Yes ❑ No |
| **Does your child have pain, severe cramps, vomiting with her menstrual periods?** | ❑ Yes ❑ No |
| **Ever or now using birth control pills?** | ❑ Yes ❑ No |

| **WEIGHT MANAGEMENT HISTORY** | |
|---|---|
| **Has your child/teen ever tried to lose weight by dieting?** | ❑ Yes ❑ No |
| **If yes, what type of diets?** | |
| **If yes, how successful was the dieting?** | |

_____ _____

**Signature of Patient/Legally Authorized Representative** **Date**

_____ _____

**Printed Name of Patient/Legally Authorized Representative** **Relationship to Patient**

_____ _____ _____

**Practitioner Signature** **Date** **Time**

_____

**Practitioner Printed Name**