

**WEISS & MASHBURN, MD, PA**  
**NEW PATIENT QUESTIONNAIRE – PEDIATRIC & ADOLESCENT**

TODAY'S DATE: \_\_\_\_\_

NAME: \_\_\_\_\_  
( LAST) (FIRST ) (MI)

AGE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_ / \_\_\_\_ / \_\_\_\_ SEX:  MALE  FEMALE

WEIGHT: \_\_\_\_\_ RACE: \_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_

HEIGHT: \_\_\_\_\_ PEDIATRICIAN: \_\_\_\_\_

**NATURE OF TODAY'S PROBLEM:**

**GENERAL HEALTH HISTORY**

PAST MEDICAL HISTORY

ANY HISTORY OF THE FOLLOWING?

ASTHMA	<input type="checkbox"/> YES	<input type="checkbox"/> NO
HEART PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
SEIZURES	<input type="checkbox"/> YES	<input type="checkbox"/> NO
BLOOD CLOTTING PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO
MOUTH BREATHING, SNORING	<input type="checkbox"/> YES	<input type="checkbox"/> NO
ANESTHESIA PROBLEMS	<input type="checkbox"/> YES	<input type="checkbox"/> NO

OTHER MEDICAL PROBLEMS?  YES  NO

\_\_\_\_\_  
\_\_\_\_\_

IS THE CHILD TAKING ANY MEDICATIONS?  YES  NO

LIST ALL MEDICATIONS AND DOSAGES:

MEDICATION _____	DOSE _____
MEDICATION _____	DOSE _____
MEDICATION _____	DOSE _____

DOES THE CHILD HAVE ANY ALLERGIES (HAYFEVER, MEDICATIONS, **LATEX GLOVES**) ?

YES  NO

IF YES, PLEASE LIST **ALL** ALLERGIES

\_\_\_\_\_

HAS THE CHILD HAD ANY PRIOR SURGERIES?  YES  NO

SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

SURGERY \_\_\_\_\_ DATE \_\_\_\_\_

IS THERE A FAMILY HISTORY OF HEARING LOSS?  YES  NO

ANY DEVELOPMENTAL DELAYS:  YES  NO

REVIEWED BY: \_\_\_\_\_

DATE: \_\_\_\_\_

\_\_\_\_\_, M.D.

DATE: \_\_\_\_\_