BETHESDA PEDIATRICS
Eric B. Nyman, M.D. (Chandler Office)

Patient Questionnaire

Child's Name: _____ DOB: _____

PREGNANCY & BIRTH:
Mother's Age at pregnancy: _____
Any Illness during pregnancy? ___ Y ___ N
If yes, explain: _____
Medications during pregnancy: (excl. vitamins & iron)
Smoking/Alcohol/Street Drugs during pregnancy?
___ Y ___ N if yes, explain: _____
Was baby early – late – on time? _____
Type of Delivery? _____
Birth Weight: _____ Length: _____
Hospital/Place of Delivery: _____
Complications: ___ Y ___ N
If yes, explain: _____
Problems with baby at birth:
Breathing? ___ Y ___ N Jaundice? ___ Y ___ N
Other: _____

PAST MEDICAL HISTORY:
Allergic Reactions:
Medicine: ___ Y ___ N
If yes, explain: _____
Animals: ___ Y ___ N
If yes, explain: _____
Insect Bites: ___ Y ___ N
If yes, explain: _____
Other allergies (please explain): _____
Immunizations – up-to-date? ___ Y ___ N
Hospitalizations (when-where-why?): _____
Serious Injuries (when-where?): _____
Measles: ___ Y ___ N Mumps: ___ Y ___ N
Chicken Pox: ___ Y ___ N
Whooping Cough: ___ Y ___ N Asthma: ___ Y ___ N
Eczema: ___ Y ___ N Anemia: ___ Y ___ N
Seizures: ___ Y ___ N
Recurrent Infections? (3 or more)
Ear: ___ Y ___ N Throat: ___ Y ___ N Eye: ___ Y ___ N
Problems with:
Hearing: ___ Y ___ N Vision: ___ Y ___ N

FEEDING & NUTRITION:
Food Allergies: _____
Appetite usually good? ___ Y ___ N
Colic or feeding problems during the first 3 mos? Y / N
Breast Fed? Y / N Number of Months: _____
Formula? Y / N Brand:
Vitamins? Y / N
Special Diet? Y / N explain? _____

FAMILY PROFILE:
Father's Age: _____ Highest School Grade: _____
Mother's Age: _____ Highest School Grade: _____
List child's siblings & ages:

FAMILY MEDICAL HISTORY:
Anemia/Blood Disorder: Y / N Epilepsy/Seizures: Y / N
Asthma: Y / N Heart Disease: Y / N
Mental Retardation: Y / N Drug Problem: Y / N
High Blood Pressure: Y / N Alcoholism: Y / N
Cholesterol Problem: Y / N Migraine: Y / N
Cancer: Y / N Birth Defects: Y / N
Sudden Infant Death: Y / N AIDS: Y / N
Cystic Fibrosis: Y / N Birth Defects: Y / N
Diabetes: Y/ N Musc. Dystrophy: Y / N
Tuberculosis: Y / N Arthritis: Y / N
Depression: Y / N Psychiatric Prob: Y / N

DEVELOPMENT & BEHAVIOR:
Age when: Sat Alone: _____ Walked: _____
Toilet Trained: _____ Bicycled: _____
Development compared to other children?
behind / similar / advanced
Learning problems? Y / N if yes, explain: _____
Behavior problems? Y / N if yes, explain: _____
Bedwetting Problems? Y / N Sleeping Problems? Y / N
Hobbies/Sports/Social Activities: _____

Name of Person completing Questionnaire **Relationship to Child**

Signature of Person completing Questionnaire **Today's Date**

PLEASE COMPLETE BOTH SIDES OF THIS FORM