LORI MCAULIFFFE, M.D., P.A.

New Patient Questionnaire

(to be completed by parent/guardian)

Child's Name: ________________________________ **Child's Date of Birth:** __________________________

Today's Date: _____________________

Mother's Name: ______________________________ Father's Name: ________________________________

Mother's Age: ______________________________ Father's Age: _______________________________

Mother's Occupation: ______________________________ Father's Occupation: ____________________

Birth History:

Birth Hospital: ____

Any Pregnancy Complications? ____

Any Delivery Complications? ____

Past Medical History:

Name of Child's previous MD: ____

Please list any hospitalizations: ____

Please list any surgeries: ____

Please list any specialists your child sees/saw: ____

Allergy History:

Has your child ever had an allergic reaction to a medication or vaccine? ___ No ___ Yes

Which? ____

What was the reaction? ____

Medication History:

My child is currently taking the following medications: ____

Family History:

Are Mom and Dad both in good health? ___ Yes ___ No

Explain "no" answers: ____

Are there any diseases which "run in the family?" ___ Yes ___ No Which? _____________________________

Social History:

Are Mom and Dad married? ___ Yes ___ No

Is either parent a smoker? ___ Yes ___ No

If there is a gun in your home,please keep it locked and unloaded.

Do you own any pets? ___ Yes ___ NoWhich? _________________________

Do you feel safe in your home? ___ Yes ___ No

Does your child ride in an automobile safety seat? ___ Yes ___ No