Welcome to
New England Allergy, Asthma, Immunology, Pediatric and Primary Care, PLLC
Your family's home for primary and specialty care!

New Pediatric Primary Care Questionnaire

First and Last Name: _____ Date of Birth_____

Parent and/or Guardian Name(s), Relationships, Phone Numbers:

_____

_____

Parental Occupation(s): _____

Prior/Referring Doctor_____ Date of last Physical Exam:_____

Birth History

Was the patient born at full term? Yes/No If no, how many weeks? _____ Vaginal or c-section?_____

Any complications with pregnancy and/or delivery? If so, please describe: _____

Did baby spend any time in special care nursery or the NICU? If so, please describe and share if any help with breathing or feeding was needed:_____

_____

Growth and Development

Has the patient been growing and developing as expected for age, meeting milestones? Yes/No
If not, please describe how so and any interventions or specialists involved _____

_____

_____

Any concerns about growth or development today? _____

Medical, Surgical and Hospitalization History

Does the patient have any known medical problems? Yes/No If so, please specify: _____

_____

_____

Have they had any surgeries? Yes/No If so, please specify:_____

If assigned ‘male’ at birth, were they circumcised? Yes/No

Has the patient ever been admitted to the hospital? If so, why and for how long: _____

_____

_____

Any Emergency Room or Urgent Care visits in the past year? Yes/No If so, please describe:

_____

_____

Allergies

Please list the allergen as well as reaction, any treatment required

_____

_____

_____

Medications

Please list all prescribed and over-the-counter medications, vitamins, and supplements

_____

_____

_____

_____

Immunizations

Is this patient up-to-date for their age with standard vaccinations? Yes / No If not, please elaborate: _____

_____

Did this patient receive a flu shot this year? Yes / No

Did this patient receive any COVID-19 vaccinations? Yes / No Brand_____ Date of Last Dose_____

When was this patient’s last episode of COVID-19, influenza, or RSV? Did they have to go to the ER or stay in the hospital?

_____

Mental Health History

Does the patient have any known or strongly suspected psychiatric diagnoses, such as ADHD, bipolar disorder, anxiety or depression? Yes/No If so, please describe:

_____

_____

Any new concerns about attention, concentration? Yes/No

Does this patient have an IEP or 504 at school? Yes/No If so, when was it last updated? _____

Does your child receive Early Intervention, therapy, counseling, or other specialists? Yes/No

If so, describe and include contacts you wish for us to have: _____

_____

Do you have any mental health concerns for your child today? _____

Family History

Please include mental health conditions that may run in the family, as well

Relative	Age (please indicate if living or deceased)	Medical conditions (Healthy; diabetes, high blood pressure, cholesterol, heart disease, asthma, allergies, eczema, cancer and type of cancer, stroke, thyroid disease, autoimmune conditions, etc) **Please note if any conditions in family diagnosed at young age**
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sibling (Brother/Sister)		
Sibling (Brother/Sister)		
Sibling (Brother/Sister)		
Other relatives or unknown Exact relation:		

Puberty History

Circle the answers that apply

At what age was this patient's first period? _____

If menstruating, how frequently? How long do they last? Severe cramping? Heavy bleeding? Concerns?

_____

Any signs of puberty? Pubic hair armpit hair acne body odor breast development growth spurt

Family history of delayed or early puberty? Yes/No If so, describe: _____

Social History

What school does this child attend and what grade? _____

What are some hobbies or activities outside of school? _____

Who lives at home with this child? _____

Are there difficulties obtaining resources like heat, electricity, or food at home?_____

Does anyone smoke, juule, vape, or use e-cigarettes at home? _____

Safety

Does this patient feel safe at home? _____

Are there working smoke detectors and carbon monoxide detectors at home? _____

Do you wear seatbelts? Yes No Sometimes

Has the patient ever been driven in a car by someone under the influence of drugs or alcohol? Yes No

If yes, please elaborate: _____

Does this patient wear sunscreen? _____

Do you perform regular tick checks in the spring through fall after being outdoors? Yes No Sometimes

Are there firearms, guns, or other weapons at home? Yes No Unsure

Are you an "emancipated minor"? If so, please describe the circumstances: _____

_____