#

Previsit Questionnaire

**Patient/Parent Questionnaire**

**Name of Child:**

**DOB [dd/mm/yy]:**

**PHN:**

**Family Dr:**

**Pharmacy & Fax no:**

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**Phone no:**

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Mothers name:

Fathers name:

Are parents living together:

If you are not the Parent, relationship to the child:

Does your child have siblings? Please add their names and ages:

Does anyone in the household smoke?

**What are your main concerns with respect to your child and how would you like us to help?**

**Medical history**

Did Mother have any problems during pregnancy with this child. If yes, please tick relevant boxes:

* High Blood pressure
* Diabetes
* Illnesses
* Alcohol
* Smoking
* Drugs
* Other (please specify)

Was your baby born at the right time (gestation)?

* Term (37-42 weeks)
* Preterm (<37 weeks) Please specify gestation\_\_\_\_\_\_\_\_\_\_\_\_\_
* Post-term (>42 weeks)

Was your baby admitted to the Neonatal unit (NICU)?

* Yes
* No

What were the main issues in NICU?

* Breathing problems
* Feeding problems
* Sepsis/Infection
* Jaundice requiring phototherapy

Any other relevant medical history including illness, surgery or hospitalizations?

Does your child take any regular medications? If yes, please list:

Does your child have any allergies?

**Developmental history:**

When did your child begin to

* sit
* walk
* talk

Which school does your child go to?

Grade?

Any other social concerns?

Any academic concerns?

Are there any problems you would prefer not to discuss in front of your child? Please Specify