New Patient Questionnaire

VALLE VERDE PEDIATRICS
15525 Pomerado Rd
Suite B-1
Poway, CA 92064
P (858) 487-8333
F (858) 487-0856
vvpeds.com

Valle Verde PEDIATRICS

PATIENT INFORMATION

Patient's full name: _____

Birth date: _____ Child's sex: ○ Male ○ Female

Address: _____

City: _____ State: _____ Zip code: _____

Email: _____ Primary phone #: _____

PARENT INFORMATION

Mother's full name: _____

Birth date: _____

Father's full name: _____

Birth date: _____

INSURANCE INFORMATION

Skip if physical insurance brought at intake appointment.

Primary insurance: _____

Group #: _____ ID #: _____

Secondary insurance: _____

Group #: _____ ID #: _____

PREGNANCY AND BIRTH HISTORY

Mother's age at birth: _____ Father's age at birth: _____

Any complications during pregnancy or birth?	Length of hospital stay:

NEWBORN HISTORY

Birth weight: _____ Birth length: _____

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Delivery type: _____ Head circumference: _____

Hospital / City / State: _____ Check one: ○ Formula ○ Breast milk

MEDICAL HISTORY

Where has child gone for check-ups previously? _____

_____

Date of last medical check-up: _____ Date of last dental check-up: _____

Is your child up to date on all immunizations? *Please supply immunization records.* ○ Yes ○ No

Hospitalizations or surgeries: _____

Significant illnesses: _____

Female patients: Age period started _____

Any recent lab tests: _____

Any recent imaging tests: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING (CIRCLE AND SPECIFY DATE):

Chicken Pox	Mumps	Bed wetting (>5 y/o)
Vision Problems	Allergies	Pneumonia
Asthma	Kidney or bladder infection	Frequent throat infection
Measles	Broken bones	Diabetes
Heart murmur	Frequent ear infections	Seizures
Headaches	Breathing trouble	Anemia
Eczema	Sickle cell disease / trait	Abdominal pain
TB	Fevers	Other

List all current medications: _____

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FAMILY HISTORY

Relationship: _____ Living: ○ Yes ○ No Age: _____

Major medical problems and/or cause of death: _____

Relationship: _____ Living: ○ Yes ○ No Age: _____

Major medical problems and/or cause of death: _____

Relationship: _____ Living: ○ Yes ○ No Age: _____

Major medical problems and/or cause of death: _____

HAVE ANY OF THE CHILD'S CLOSE RELATIVES HAD ANY OF THE FOLLOWING CONDITIONS:

Condition	Relative	Condition	Relative
Diabetes		Kidney problems	
Cancer		Heart disease	
Seizures		Skin problems	
Allergies / Asthma		Anemia	
Bleeding problems		Congenital defects	
High blood pressure		Chemical dependency	
Mental illness		Other:	

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SOCIAL / CULTURAL HISTORY

School name: _____ Grade level: _____

Language(s) spoken at home: _____

Number of family members living in the household: _____

CONFIDENTIAL CHANNEL COMMUNICATION REQUEST

I consent the use of the following confidential channels for the communication of information related to:

Child's name: _____

○ Phone ○ OK to leave voicemails ○ Mail ○ Email address: _____

HOW DID YOU HEAR ABOUT US?

○ Search engine (Google, Bing) ○ Social media ○ Friend or colleague ○ Online advertisement ○ Blog or article

Other (please specify): _____

_____

_____

_____ _____

Parent / Guardian Signature Date