



Baldwin Pediatrics
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New Patient Questionnaire

Patient Name _____ Mother's Name _____ Age _____
Father's Name _____ Age _____ Patient Date of Birth _____
Emergency contact _____

Family History Siblings' Names: _____

Are the child's parents both in good health? _____

Referred by [May we know the full name of the referring party, and the child's name, if our patient, so we can send them our thanks]

Check any diseases that the child's parents, grandparents, brothers, sisters, aunts, or uncles have had:

Asthma/ Allergies/ Diabetes /High Blood Pressure/ Heart disease before age 50/ High Cholesterol /Seizures/ Cancer/ Tuberculosis/Kidney Stones /Sudden unexplained death /Mental Illness

List any other significant chronic illnesses in the family:

Is there a smoker in the household? Yes No

Do both parents live at home? Yes No If "No", with whom does the patient live? _____

Is there a gun in the household? Yes No If "Yes", is it securely locked? Yes No

Pregnancy and Birth

Mother's age at child's birth _____

Did mother have an illness during pregnancy? Yes No List the illness:

Did she take medications other than vitamins? Yes No List the medication:

Was the baby premature? Yes No If "Yes", the baby was born at _____ weeks

What was the birth weight? _____

What type of delivery? Vaginal C-Section

Did the baby have trouble while in the hospital? Yes No If "Yes", what kind of trouble?

Past Medical History (these questions refer to the child)

Any allergic reactions to medications, foods, Yes No Which ones?
_____ or insect bites or stings?

Any reactions to immunizations? Yes No Which ones?

Any hospitalizations? Yes No Why, at what age? _____

Any surgeries? Yes No What kind, at what age? _____

Any serious injuries? Yes No What kind, at what age? _____

Any medications taken regularly? Yes No Which ones?

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT

*I hereby acknowledge that I have been presented with a copy of Baldwin
Pediatrixs' Notice of Privacy Practices containing a more complete description
of the uses and disclosures of my protected health information and my
individual rights with respect to my protected health information.*

PATIENT NAME:

SIGNATURE:

DATE:

OFFICE USE ONLY

I have attempted to obtain the patient's signature in acknowledgement of this **Notice of
Privacy Practice Acknowledgement**, but was unable to do so as documented below:

Date: Initials: Reason