

VIRGINIA PEDIATRIC GROUP, LTD

New Patient Pre-Visit Questionnaire

Welcome to Virginia Pediatric Group, Ltd. We greatly appreciate that you chose us to provide care for your family. Our providers will be asking you about your child's present medical condition and problems, but to allow us to learn more about your child, please fill out this questionnaire. Although some questions may be a little startling, please understand that they address current health issues. For confidentiality, please complete the questionnaire in the exam room and give it to your provider. Once again, thank you for choosing our practice to handle your family's health care needs.

Patient Name: _____ DOB: _____

Informant: _____ Relationship: _____

When was your child's last well child health examination? _____ Date: _____

Did you bring a copy of your child's immunization record? Yes _____ No _____

If yes, please provide it to the physician, if no please get a copy and send it to our office as soon as possible

Name and Phone # of Prior Pediatrician _____

Is your child hearing impaired? Yes _____ No _____

Is your child vision impaired? Yes _____ No _____

Are you concerned about your child's hearing or vision? Yes _____ No _____

Has your child been exposed to lead? Yes _____ No _____

Age of house? _____

Age of day care building? _____

Is there a gun/weapon in your home? Yes _____ No _____

Is it secured or in a locked vault? Yes _____ No _____

Is your home tobacco and smoke free? Yes _____ No _____

Are you worried about your child's nutrition or diet? Yes _____ No _____

Has your child been to the dentist? Yes _____ No _____

When? _____

Has your child had any international travel? Yes _____ No _____

If yes, where, when and for how long? _____

What is the child's family structure? _____

Do you have any concerns about your child's mental health? Yes _____ No _____

Are you worried about your child's or your own safety? Yes _____ No _____