# NEW PATIENT QUESTIONNAIRE

**Pediatric Infectious Disease**

**Last Name:** ___________________________  **First Name:** ___________________________  **Date of Birth:** __________

---

## Has your child had any of these symptoms?

<table>
<thead>
<tr>
<th>GENERAL</th>
<th>EYES, EARS, NECK</th>
<th>SKIN</th>
<th>NEUROLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fever</td>
<td>Pink Eyes/Red Eyes</td>
<td>Rash</td>
<td>Seizures</td>
</tr>
<tr>
<td>Weight Loss</td>
<td>Stuffy Nose</td>
<td>Sores</td>
<td>Fainting</td>
</tr>
<tr>
<td>Weight Gain</td>
<td>Ear Ache</td>
<td>Eczema</td>
<td>Weakness</td>
</tr>
<tr>
<td>Tiredness</td>
<td>Ear Infection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Headaches</td>
<td>Mouth Sores</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Swollen Glands</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stiff Neck</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ABDOMINAL</th>
<th>MUSCLES AND BONES</th>
<th>LUNGS</th>
<th>GENITAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vomiting</td>
<td>Aches/Pains</td>
<td>Cough</td>
<td>Pain</td>
</tr>
<tr>
<td>Abdominal Pain</td>
<td>Swelling</td>
<td>Wheezing</td>
<td>Discharge</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Redness</td>
<td>Asthma</td>
<td>Rash</td>
</tr>
<tr>
<td>Constipation</td>
<td>Limp</td>
<td>TB</td>
<td></td>
</tr>
<tr>
<td>Heart Burn</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reflux</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

## Is there family history of any of the following?

- Fevers
- Ear Infection
- Sinus Infection
- Heart Disease
- Diabetes
- Any Other Problems: ___________________________

- Cancer
- Immune System Problems
- Acid Reflux
- Urinary/Kidney Problems
- Allergies

- Tonsillectomy
- Asthma
- Arthritis
- Rheumatologic Disease
- Lupus/SLE

---

## Any surgeries?

______________________________________________________________________

---

## Who lives with the child?

______________________________________________________________________

---

## In the past six months, has the child or family been exposed to or participated in:

- Travel Outside of Florida
- Travel Outside of U.S.
- Farms/Wild Animals
- Cats
- Dogs
- Mice, Rodent, or Rabbits
- Reptiles or Amphibians
- Birds, Bats, or Nest
- Camping or Hunting
- Ticks or Mosquitoes
- Tuberculosis
- Chemical
- Toxins

---

## Has your child spent any time in the hospital?  If so, how long ago?

______________________________________________________________________

---

---