



New Patient Questionnaire

Valle Verde Pediatrics | 15525 Pomerado Rd, Suite B-3
Poway, CA 92064
Phone: 858-487-8333 | Fax: 858-487-0856

PATIENT INFORMATION

Patient's Full Name: _____
Birth Date: _____ Child's Sex: Male Female
Address: _____
City: _____ State: _____ ZIP _____
Email: _____ Primary Phone #: _____

PARENT INFORMATION

Mother's Full Name: _____
Date of Birth: _____ SSN#: _____
Father's Full Name: _____
Date of Birth: _____ SSN#: _____

INSURANCE INFORMATION

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:
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NEWBORN HISTORY

Birth Weight: _____ Birth length: _____



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Delivery Type: _____ Head Circumference: _____

Hospital, City, State: _____ Check One: Formula Breastmilk

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
Measels	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
Diabetes	
Cancer	
Seizures	
Allergies/ asthma	
Bleeding problems	
High blood pressure	
Mental illness	

Condition	Relative
Kidney problems	
Heart disease	
Skin problems	
Anemia	
Congenital defects	
Chemical dependency	
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) _____

Parent/ Guardian Signature

Date