Today's Date____________________

Lawrence F. Rahall D.O. P.C.
638 Portersville Road
Ellwood City, Pa 16117

PEDIATRIC NEW PATIENT QUESTIONNAIRE

Childs Name____ Date of Birth______________ ☐ Boy ☐ Girl

Age ______ Social Security # ____________________ Phone ________________ School _______________________________

Address____

Emergency Contact____ Relation ______________ Phone __________________

Reason for today's visit____

Medical History

Illnesses, past surgeries (please provide dates) ____

____

Allergies and reactions ____

Daily medications (include OTC) ____

Birth Weight _______________ Length _____________ Type of delivery ____________________________________

Are you ☐ Breast Feeding ☐Formula (what type) _________________________ ☐ Vitamins/Fluoride

PLEASE ATTACH COPY OF IMMUNIZATION RECORDS

Family Information

Mothers Name____ ☐ Biological ☐ Stepmother ☐ Legal Guardian

Date of Birth _____________ Blood Type ___________ Rh Type(+ or -) ________ Home Phone _____________________

Employer ____ Work Phone ______________

Fathers Name ____ ☐ Biological ☐ Stepfather ☐ Legal Guardian

Date of Birth ________________________ Blood Type ____________ Home phone ________________________________

Employer ____ Work Phone ______________

Family history of disease

	Relation/age
Heart Disease	______________________________
High Blood Pressure	______________________________
Stroke	______________________________
Cancer (type and location)	______________________________
Leukemia	______________________________
Asthma	______________________________
Diabetes	______________________________
Congenital defects	______________________________

Brothers and Sisters (List names and ages)

____ ______________

____ ______________

____ ______________

____ ______________

Insurance information

Primary Insurance ____

Insured's Name ____ Date of birth ______________

Policy Number (I.D. #)______________________________ Group Number __________________

Address for submitting claims____

Signature of Parent(s) or Legal Guardian(s) who accept financial responsibility for the care of the above family member.

____ ________________

Signature of Parent/Legal Guardian Date