Comprehensive Childcare Associates

Patient Questionnaire

Patient Name _____ **Account #** _____

1 Any on-going health concerns?

_____

_____

2 Any past medical problems?

_____

_____

3 Any hospitalization or surgeries?

_____

_____

4 Does your child see other physician's or mental health care workers?

_____

5 Any allergies?

_____

6 Who is living with you and your child?

_____

7 Any OTC or prescription medicines?

_____

8 Any vaccines due?

_____

9 What questions do you have for the doctor today?

_____

_____

_____

Notes:

_____

_____

_____

Form completed by: _____

Information entered into patients EMR/dashboard: **Date:** _____

Document scanned and placed in folder: **Date:** _____

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