MI KIDS PEDIATRICS

NEW PATIENT QUESTIONNAIRE

Patient Name:

Last_____ First_____ MI____ Nickname _____ DOB___/____/_____

❑ Male ❑ Female Person completing history_____ Date___/____/_____

Family profile:

❑ Parent ❑ Guardian

Name_____ Relationship to patient_____ Lives with patient ❑ Yes ❑ No

Age_____ Employment_____ DOB___/____/_____

Major health issues_____

❑ Parent ❑ Guardian

Name_____ Relationship to patient_____ Lives with patient ❑ Yes ❑ No

Age_____ Employment_____ DOB___/____/_____

Major health issues_____

Child's brothers and sisters:

#1 Full name_____ ❑ Male ❑ Female DOB____/____/_____

Major health issues_____

#2 Full name_____ Male Female DOB____/____/_____

Major health issues_____

#3 Full name_____ Male Female DOB____/____/_____

Major health issues_____

#4 Full name_____ Male Female DOB____/____/_____

Major health issues_____

Other members living in the household_____

Is you child in daycare? ❑ In-home daycare/ ❑ Daycare center

Prenatal History:

Which pregnancy was this for you (1st, 2nd, etc)? _____

Have you ever miscarried? ❑ Yes ❑ No

Have any of your chidren died? ❑ Yes ❑ No If yes, what was the reason _____

Did you receive prenatal care during this pregnancy? ❑ Yes ❑ No

Did you have any medical problems during this pregnancy? ❑ Yes ❑ No

If yes, please list_____

During this pregnancy did you:

Smoke?	❑ Yes ❑ No	Take illegal drugs?	❑ Yes ❑ No
Use Alcohol?	❑ Yes ❑ No	Have any infections?	❑ Yes ❑ No
Use Medications?	❑ Yes ❑ No		

NEW PATIENT QUESTIONNAIRE

Birth History:

Hospital where your child was born_____

How many months pregnant were you when this child was born?_____

Were there any problems with labor or delivery? ❑ Yes ❑ No If yes, please list_____

_____

Type of delivery ❑ Vaginal ❑ Vaginal with forceps ❑ C-section Baby's birth weight_____

After birth, did the baby have (check all that apply)

❑ Jaundice ❑ Heart mumur ❑ Infection ❑ Breathing problems ❑ Birth Defect

Other problems_____

Past Medical History:

Does your child have any chronic illness/ issues? ❑ Yes ❑ No

If yes, please explain_____

Does your child see any specialists? Whom and for what?_____

Has your child had any surgeries? ❑ Yes ❑ No

If yes, please list surgeries, approximate date, hospital performed _____

_____

Has your child had any overnight stays at the hospital? ❑ Yes ❑ No

If yes, please explain hospitalizations_____

Has your child had any fractures or broken bones? ❑ Yes ❑ No

If yes, please explain _____

Does your child have any allergies to medications? ❑ Yes ❑ No

If so, please list and describe reaction _____

Does your child have any environmental allergies (pets, pollen)? ❑ Yes ❑ No

If so, please list _____

Does your child have any food allergies? ❑ Yes ❑ No

If so, please list and describe reaction _____

Does your child have any pollen allergies (bee/ wasp)? ❑ Yes ❑ No

Please circle if your child has had any issues with the following:

ADHD
Allergies
Anxiety
Asthma
Constipation
Dental issues
Depression
Developmental Delay
Diabetes
Ear infections (recurrent)
PE tube placement
Eczema
Gastroesophageal Reflux
Hearing issues
Hives/ urticaria
Prematurity
Seizures
Strep throat/ tonsillitis recurring
Snoring
Tonsillectomy
UTI
Other urinary issues
Vision difficulties

Other concerns not listed _____

_____

Who is your child's dentist? _____

NEW PATIENT QUESTIONNAIRE

Relationship	Alcohol Abuse	Allergy - severe	Anemia	Asthma	Cancer	Diabetes	Drug Abuse	Heart Attack	Hypertension	Kidney Disease	Mental Illness	Mental Retardation	Rashes/ Skin Problems	Seizures	Sickle Cell Anemia	Hearing Loss	High Cholestrol	Heart Disease	Tuberculosis	ADHD/ADD	Learning Disabilities	Vision Loss	Birth Defects
Mother																							
Father																							
Sister																							
Brother																							
Maternal Aunt																							
Maternal Uncle																							
Paternal Aunt																							
Paternal Uncle																							
Maternal Grandma																							
Maternal Grandpa																							
Paternal Grandma																							
Paternal Grandpa																							