MI KIDS PEDIATRICS

NEW PATIENT QUESTIONNAIRE

Patient Name:

Last_____ First_____ MI____ Nickname _____ DOB___/____/_____

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

Is your child adopted? ☐ Yes ☐ No Foster child? ☐ Yes ☐ No

Prenatal / Birth History: if known

Did mother receive routine 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 the mother have exposure to any of the following:

Tobacco?	☐ Yes	☐ No	Illegal drugs?	☐ Yes	☐ No
Alcohol?	☐ Yes	☐ No	Infections?	☐ Yes	☐ No
Medications?	☐ Yes	☐ No			

Any medical problems with labor or delivery? ☐ Yes ☐ No If yes, please list_____

_____

Was your child born prematurely ☐ Yes ☐ No If yes, how early _____

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?

☐ Adenoidectomy ☐ Appendectomy ☐ Circumcision ☐ Fracture ☐ Hernia repair

☐ Tonsillectomy ☐ Tympanostomy (ear tubes) and Other _____

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

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

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

If so, please list and describe reaction _____

_____

OVER ↓

NEW PATIENT QUESTIONNAIRE

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 venom allergies (bee/ wasp)? ❑ Yes ❑ No

Other concerns not listed _____

_____

Who is your child's dentist? _____

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																							
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