Partners In Pediatrics, PLC
4684 Wenmar Drive
Saginaw, MI 48604

Initial Visit Patient History Questionnaire

Patient Name: ______________________________ **DOB:** __________________

Pregnancy and Birth History:

1. Did you have any illness during your pregnancy?.. No Yes
2. Did the baby come on time?.. Yes No
3. What was the birth weight?_________lb.________oz. Did your baby have any trouble starting to breathe?....... No Yes
4. Was your baby jaundice?.. No Yes
5. Was a light used to treat the baby for jaundice?.. No Yes
6. Did the baby have any trouble while in the hospital?.. No Yes
7. Did you take any medications during the pregnancy?.. No Yes

8. Circle any of the following diseases this child's parents, grandparents, aunts, uncles, brothers or sisters have had and mark the relation to the child:

_____Alcoholism _____Allergies _____Asthma _____Diabetes
_____Cancer _____Smoking in the home _____Heart Attack _____Hay Fever
_____High Blood Pressure _____Nervous Breakdown _____Migraine _____Retardation
_____Seizure Disorder _____Tuberculosis _____Sickle Cell Disease _____Epilepsy
_____Inherited Diseases or Family Diseases _____Other________________________________

9. Are the child's parents both in good health?.. Yes No
10. Do any brothers and/or sisters have a health problem?.. No Yes
11. Have any of your children died?.. No Yes
12. Is your child on an apnea monitor?.. No Yes
    Are you using the monitor? Yes No If yes, why?____
13. Has your child had any trouble with his/her eyes or vision?.. No Yes
14. Has your child had any allergies or reactions to any food, medicines or injections?.................................. No Yes
15. Has your child ever had any significant illnesses?.. No Yes
    If yes, please list____
16. Has your child ever been hospitalized?.. No Yes
    If yes, please list____
17. Has your child had any operations?.. No Yes
    If yes, please list____
18. Has your child had to limit his activities for health reasons?.. No Yes
    If yes, in what way and why____
19. Has your child been under a physician's care in the past 12 months?.. No Yes
    If yes, for what?____
20. Is your child taking any medicine now?.. No Yes
21. Does your child have any problems in school?.. No Yes
22. Does your child have any other health problems?.. No Yes

Family History:	Ages	Height	Weight	Medical Problems
Child's Mother				
Child's Father				
Brother				
Sister				

23. Are the mother and father of this child:
    Married?................................Yes No Separated?.......................................Yes No
    Divorced?..............................Yes No Living together? ....Yes No
    Legal Guardians?.......................Yes No
24. Last grade in school finished by Mother ___________________ Father____________________

I understand the above information and guarantee this form was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes.

______________________________ ______________________________ ______________________________
Signature Relationship to child Date

Practitioner Reviewed:________________________ Date Reviewed:__________________________