MiKids Pediatrics Health Questionnaire

Patient name _____ nickname_____ Birth date ___/____/_____
☐Male ☐Female

Person completing history _____ Today's date ___/____/_____

Family Profile:

Child's mother: Name _____
Age _____ Birth date ___/____/_____
Employment _____
Major health issues_____

Child's father: Name _____
Age _____ Birth date ___/____/_____
Employment _____
Major health issues_____

Child's brothers and sisters

Name	Sex	Age	General health

Other members living in the household:

_____
_____
_____

Is your child currently in daycare? ☐Yes ☐No
If yes, what kind (center, private in home, etc)
_____

Prenatal History:

Which pregnancy was this for you (1st, 2nd, etc)? _____
Have you ever miscarried? ☐Yes ☐No
Have any of your children died? ☐Yes ☐No If yes, what was the cause? _____
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
Use Alcohol? ☐Yes ☐No
Use Medications? ☐Yes ☐No
Take illegal Drugs? ☐Yes ☐No
Have any infections? ☐Yes ☐No

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 (check one) ☐Vaginal ☐Vaginal with forceps ☐C-section
Baby's birth weight _____
After birth, did the baby have (check all that apply):
☐Jaundice ☐Heart murmur ☐Infection ☐Breathing Problems ☐Birth Defect
Other problems
_____

Family History:

Please circle any of the following diseases that any of the child's parents, grandparents, aunts, uncles, brothers or sisters have had:

Alcoholism	Cancer	Heart disease (childhood)	Mental Retardation
Allergies	Cystic Fibrosis	Heart disease (adulthood)	Seizures
Asthma	Deafness	High Cholesterol	Sickle Cell Disease
Bleeding disorders	Diabetes	Kidney Disease	Tuberculosis
Blindness	Drug abuse	Mental Illness	

Does anyone in the household smoke? ☐Yes ☐No

Feeding History:

Type of feeding (check all that apply): ☐Breast ☐Formula Kind of formula _____

Were there any feeding problems in the first 3 months?	☐Yes ☐No
Is your child's appetite usually good?	☐Yes ☐No
Do you feel like your child eats a balanced diet?	☐Yes ☐No
Does your child take vitamins?	☐Yes ☐No
Do you have fluoride in your drinking water?	☐Yes ☐No
Does your child have any problem with constipation?	☐Yes ☐No
Does your child have any food allergies?	☐Yes ☐No

Developmental and Medical History: - if applicable

At what age did your child:

Sit alone _____ Walk alone _____ Say his/her first word _____

Does your child appear to have any trouble hearing?	☐Yes ☐No
Does your child appear to have any trouble seeing?	☐Yes ☐No
Does your child have any difficulty sleeping?	☐Yes ☐No
Does your child have any problems with his/her teeth?	☐Yes ☐No
Does your child visit a dentist regularly?	☐Yes ☐No
Has your child had 3 or more ear infections?	☐Yes ☐No
Does your child have trouble going to the bathroom?	☐Yes ☐No
Has your child ever had a convulsion or seizure?	☐Yes ☐No
Has your child ever had hives or eczema?	☐Yes ☐No
Has your child ever had any wheezing or asthma?	☐Yes ☐No
Has your child ever had any allergies or reactions to medications?	☐Yes ☐No

Are your child's immunizations up to date? ☐Yes ☐No

Please date and describe all the following that apply to your child:

Broken bones: _____

Serious Accidents: _____

Operations: _____

Hospitalizations: _____

Do you have any concerns about your child not already listed? _____

_____

_____