



Initial Visit Patient History Questionnaire

4684 Wenmar Dr
Saginaw MI 48604
989.793.1095

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: _____