Capital Internal Medicine Associates, P.C.

*A New Beginning OB/GYN *CIMA Breast Center
*CIMA Main Office * Haslett Primary Care *Mount Hope Clinic
*Williamston Primary Care

PLEASE COMPLETE THIS PEDIATRIC QUESTIONNAIRE

Patient Name: ____________________________________ Birthdate: ___/___/____

Parent Name Completing Information: ____________________________Today's Date___/____/____

PARENT INFORMATION

Single:_____ Married: _____ Divorced:_____ Separated:____ Widowed:_____ Life Partner:_____

Did mother smoke during pregnancy? Yes No If so, how many packs per day? ____________

Did mother consume alcohol during pregnancy? Yes No How many per day? ______Week? _______

Did mother consume caffeine? Yes No If so, how much per day? ____________________________

Did mother take any medication during pregnancy? Yes No If so, what? _______________________

Does anyone smoke in the home? Yes No How many packs per day? _________________

Does anyone in the home use any recreational drugs? Yes No If so, what? ______________________
(Marijuana, Cocaine, LSD, Speed, Crack, Heroine, Steroids, Medications not prescribed to you)

BIRTH HISTORY

☐ Vaginal Birth ☐ Caesarian If caesarian, why? ____________________________

Length of Pregnancy (# of weeks) _____________ If Premature, how early? ________________

Birth Weight: ______________________ Birth Length: _____________________

☐ Home ☐ Hospital ☐ Birthing Center

Name of Facility: ____

City: _______________________State: __________________Zip Code: _______________________

☐ Breast Fed, How Long? ________________ ☐ Formula, Brand/Type? ________________

☐ Other: ____

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PC Employee Benefits Plan complies with applicable Federal civil rights laws
and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Spanish	ATENCIÓN:	si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-517-374-7600.
Arabic	ملحوظة:	ب رقم اتص-----ل .بالمج-----ان ل---ك تتواف------------ر اللغوي---------ة المس---اعدة خدمات ف---إن ،اللغ-----ة اذك--ر تتح--------دث كن----ت إذا 1-517-374-7600

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IMMUNIZATIONS

Were Immunization(s) given in Michigan? Yes No

If the child has received immunizations, but not in Michigan, please provide when they received them and in what state they were administered: _____

If there is another name the child may have used when receiving the immunizations, please provide the name(s): _____

PATIENT HEALTH INFORMATION

PLEASE CIRCLE IF YOUR CHILD HAS BEEN DIAGNOSED WITH:

ADD/ADHD	Abdominal Pain	Allergies	Anxiety
Asthma	Birth Complications	Bone Fracture	Cancer
Chronic Ear Infections	Concussion/Head Injury	Constipation	Depression
Eczema	Headaches	Hearing Problems	Joint Pain
Piercing(s)	Poor Appetite	Rapid Pulse	Scoliosis
Seizures	Shortness of Breath	Speech Development Delay	Tattoo(s)
Vision Problems	Weight Gain	Weight Loss	

Other: _____

Any surgical implant(s)? Yes No If yes, where? _____

Please list any surgeries: _____

RECENT TESTING ACTIVITY

Please Indicate the Most Recent Date These Test Were Performed

Lead Levels Date last tested: _____
Dental Date last exam: _____
Hearing Date last tested: _____
Vision Date last exam: _____

LIST YOUR PREVIOUS PRIMARY CARE DOCTOR and ANY SPECIALISTS THAT YOU SEE or HAVE SEEN IN THE PAST:

_____

_____

_____

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Family History: (Please check all boxes that apply in table below)

Please tell us about medical problems in your blood relatives. This can help us take better care of you. Fill out the chart below by checking all the appropriate boxes that apply to each relative.

	AGE (years old)	DECEASED (Y/N)	DIABETES	HYPERTENSION	HEART DISEASE/CHF/MI	STROKE	ASTHMA	CANCER	UNKNOWN	ALLERGIES	MENTAL ILLNESS	DEPRESSION	OSTEOPOROSIS	COPD	HYPERLIPIDEMIA	OTHER:
MOTHER		Y/N														
FATHER		Y/N														
MOTHERS MOTHER		Y/N														
MOTHERS FATHER		Y/N														
FATHERS MOTHER		Y/N														
FATHERS FATHER		Y/N														
BROTHERS		Y/N														
SISTERS		Y/N														
CHILDREN		Y/N														

CURRENT MEDICATIONS

Please list medication that you are currently taking.

PLEASE LIST MEDICATIONS YOU ARE USING:

MEDICATION TAKING	DOSAGE	REASON FOR USING

PLEASE LIST ANY ALLERGIES AND YOUR REACTION TO THEM

ALLERGY/MEDICATION	REACTION

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