Initial History Questionnaire

Patient Name:_____

Form Completed By: Date:

Birth Date:_____ Age:_____

Household

Please list all those living in the child's home.

Name	Relationship to child	Birthdate	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

_____

What is the child's living situation if not with both biological parents?

◯ Lives with adoptive parents ◯ Joint custody ◯ Single custody

◯ Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History ◯ Don't know birth history

Birth weight _____ Born at term?_____ or _____weeks. Was the delivery: ◯ Vaginal ◯ Cesarean

If cesarean, why? _____

Was initial feeding ◯Formula ◯Breast milk How long breastfed? _____

Did your baby go home with mother from hospital? _____

Were there any prenatal or neonatal complications? ◯Yes ◯No

Explain:_____

Was NICU stay required? ◯Yes ◯No

Explain:_____

During pregnancy, did mother

Use tobacco? ◯Yes ◯No Drink Alcohol? ◯Yes ◯No Use drugs or medications? ◯Yes ◯No Prenatal vitamins? ◯Yes ◯No

What_____When_____

General

Do you consider your child to be in good health? ◯Yes ◯No

Explain:_____

Does your child have any serious illnesses or medical conditions? ◯Yes ◯No

Explain:_____

Has your child had any surgery? ◯Yes ◯No

Explain:_____

Has your child ever been hospitalized ◯Yes ◯No

Explain:_____

Is your child allergic to medicine or drugs? ◯Yes ◯No

Explain:_____

Do you feel your family has enough to eat? ◯Yes ◯No

Explain:_____

Are there any guns in the home? ◯Yes ◯No If yes, are they locked safely away from your child's reach? ◯Yes ◯No

Biological Family History

Have any family members had the following?

Childhood hearing loss	◯Yes ◯No	Who: _____	Comments:_____
Nasal allergies	◯Yes ◯No	Who: _____	Comments:_____
Asthma	◯Yes ◯No	Who: _____	Comments:_____
Tuberculosis	◯Yes ◯No	Who: _____	Comments:_____
Heart disease (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
High cholesterol/needs medication	◯Yes ◯No	Who: _____	Comments:_____
Anemia	◯Yes ◯No	Who: _____	Comments:_____
Bleeding disorder	◯Yes ◯No	Who: _____	Comments:_____
Cancer (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
Liver disease	◯Yes ◯No	Who: _____	Comments:_____
Kidney disease	◯Yes ◯No	Who: _____	Comments:_____

Biological Family History (continued from previous page)

Diabetes (before 55 years old)	◯Yes ◯No	Who: _____	Comments:_____
Bed-wetting (after 10 years old)	◯Yes ◯No	Who: _____	Comments:_____
Obesity	◯Yes ◯No	Who: _____	Comments:_____
Epilepsy or convulsions	◯Yes ◯No	Who: _____	Comments:_____
Alcohol abuse	◯Yes ◯No	Who: _____	Comments:_____
Drug abuse	◯Yes ◯No	Who: _____	Comments:_____
Mental illness/depression	◯Yes ◯No	Who: _____	Comments:_____
Developmental disability	◯Yes ◯No	Who: _____	Comments:_____
Immune problems, HIV, or AIDS	◯Yes ◯No	Who: _____	Comments:_____
Tobacco use	◯Yes ◯No	Who: _____	Comments:_____

Additional family history: _____

_____

Past History

Does your child have, or has your child ever had,

Chickenpox	◯Yes ◯No	When: _____
Frequent ear infections	◯Yes ◯No	Explain: _____
Problems with ears or hearing	◯Yes ◯No	Explain: _____
Nasal allergies	◯Yes ◯No	Explain: _____
Problems with eyes or vision	◯Yes ◯No	Explain: _____
Asthma, bronchitis, bronchiolitis, or pneumonia	◯Yes ◯No	Explain: _____
Any heart problem or heart murmur	◯Yes ◯No	Explain: _____
Anemia or bleeding problem	◯Yes ◯No	Explain: _____
Blood transfusion	◯Yes ◯No	Explain: _____
HIV	◯Yes ◯No	Explain: _____
Organ transplant	◯Yes ◯No	Explain: _____
Malignancy/bone marrow transplant	◯Yes ◯No	Explain: _____
Chemotherapy	◯Yes ◯No	Explain: _____
Frequent abdominal pain	◯Yes ◯No	Explain: _____
Constipation requiring doctor visits	◯Yes ◯No	Explain: _____
Recurrent urinary tract infections and problems	◯Yes ◯No	Explain: _____
Congenital cataracts/retinoblastoma	◯Yes ◯No	Explain: _____
Metabolic/Genetic disorders	◯Yes ◯No	Explain: _____
Cancer	◯Yes ◯No	Explain: _____
Kidney disease or urologic malformations	◯Yes ◯No	Explain: _____
Bed-wetting (after 5 years old)	◯Yes ◯No	Explain: _____
Sleep problems; snoring	◯Yes ◯No	Explain: _____
Chronic skin problems (eg. acne, eczema)	◯Yes ◯No	Explain: _____
Frequent headaches	◯Yes ◯No	Explain: _____
Convulsions or other neurologic problems	◯Yes ◯No	Explain: _____
Obesity	◯Yes ◯No	Explain: _____
Diabetes	◯Yes ◯No	Explain: _____
Thyroid or other endocrine problems	◯Yes ◯No	Explain: _____
High blood pressure	◯Yes ◯No	Explain: _____
History of serious injuries/fractures/concussions	◯Yes ◯No	Explain: _____
Use of alcohol or drugs	◯Yes ◯No	Explain: _____
Tobacco use	◯Yes ◯No	Explain: _____
ADHD/anxiety/mood problems/depression	◯Yes ◯No	Explain: _____
Developmental delay	◯Yes ◯No	Explain: _____
History of family violence	◯Yes ◯No	Explain: _____
Sexually transmitted infections	◯Yes ◯No	Explain: _____

Any other significant problem_____

_____