

Initial History Questionnaire		Name: Last, First		
FORM COMPLETED BY	DATE COMPLETED	BIRTH DATE	AGE	SEX M F

Household

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

Name	Relationship to child	Birth date	Health Problems	Occupation

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

If mother and father are not living together or if child does not live with parents, what is the child's custody status? _____

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

What languages are spoken in the home?
 English Spanish Other _____

Birth History

- | | |
|---|---|
| Did mother have any illness or problem with the pregnancy? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| During the pregnancy did mother use medications, drugs, smoke or drink alcohol? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Was the delivery | <input type="checkbox"/> Vaginal? <input type="checkbox"/> C-section? |
| Was the baby | <input type="checkbox"/> Term? <input type="checkbox"/> Early? Gestational Age? _____ weeks |
| What was the baby's birth weight? _____ lbs _____ oz. | |
| Did your baby have any problems right after birth? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| What was the initial feeding? | <input type="checkbox"/> Breast <input type="checkbox"/> Formula |
| Did your baby pass the hearing screen? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did your baby get the Hepatitis B vaccine? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Did your baby go home with mother from the hospital? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |

General

- | | |
|--|--|
| Do you consider your child to be in good health? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Does your child have any serious illness or medical condition? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Has your child had serious injuries or accidents? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Has your child had any surgery? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Has your child ever been hospitalized? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Is your child allergic to any medicines or drugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Are your child's immunizations up-to-date? | <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know |
- List all your child's current medications:
- | | | |
|------------|------------|-----------------|
| Name _____ | Dose _____ | Frequency _____ |
| Name _____ | Dose _____ | Frequency _____ |
| Name _____ | Dose _____ | Frequency _____ |

Development

- | | |
|---|---|
| Are you concerned about your child's physical development? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Are you concerned about your child's mental or emotional development? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| <i>If your child is in school:</i> | |
| What grades does your child get? | <input type="checkbox"/> Low <input type="checkbox"/> Average <input type="checkbox"/> High |
| Does your child have behavior problems in school? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Has he/she failed or repeated a grade in school? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |
| Is he/she in special or resource classes? | <input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____ |

Name _____ Birth Date _____

Patient Past History

Does your child have, or has he/she ever had:

- | | | | |
|--|------------------------------|-----------------------------|---------------|
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with ears or hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Problems with eyes or vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any heart problem or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Anemia, bleeding problem or blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Constipation requiring doctor visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bladder or kidney infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Bed-wetting (after 5 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Has she started her menstrual periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| (For girls) Are there problems with her periods? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Sprains or fractures | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Convulsions or other neurologic problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Concussion or head trauma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Thyroid or other endocrine problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Obesity or Eating Disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Use of alcohol or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
| Any other significant problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Explain _____ |
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-
-

Family History

Have any family members had the following:

- | | | | | |
|---|------------------------------|-----------------------------|-----------|----------------|
| Deafness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Sudden Death | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart Disease (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia / Bleeding disorder | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol or drug abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental Illness | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
- Additional family history _____
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