

INITIAL HISTORY QUESTIONNAIRE

FORM COMPLETED BY _____

DATE COMPLETED _____

PATIENT NAME _____

ID NUMBER _____

BIRTH DATE _____

AGE _____

M _____

F _____

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 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 or parents not in the home? _____

BIRTH HISTORY

Birth weight _____ Was the delivery Vaginal? Cesarean?

Was the baby born at term? _____ Early? _____ Late? _____ If cesarean, why? _____

If early, how many weeks' gestation? _____ Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy? Yes No Yes No Explain _____

Explain _____

Was initial feeding Breast? Bottle?

During pregnancy, did mother:

Smoke Yes No Drink Alcohol Yes No Did your baby go home with mother from the hospital?

Use Drugs or medications Yes No Yes No Explain _____

What _____ When _____

GENERAL

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

Does your child have any serious illness or medical condition? Yes No Explain _____

Has your child had serious injuries or accidents? 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 any medicines or drugs? Yes No Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? Yes No Explain _____

Are you concerned about your child's mental or emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

If your child is in school:

How is his/her behavior? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

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 _____
Tuberculosis	<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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
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 _____
Bed-wetting (after 10 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 abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
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 _____				

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 _____
Nasal 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 or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
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 _____
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 _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Any other significant problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____