INITIAL HISTORY QUESTIONNAIRE

Patient's Last Name: First Name: M.I.

Date of Birth: ☐ M ☐ F

Forms Completed By: Date Completed:

HOUSEHOLD

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

NAME	RELATIONSHIP TO CHILD	DOB	HEALTH PROBLEMS

Are there siblings not listed? If so, please list their names, 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 house, how often does he/she see the parent/parents not in the home? ______________________________

BIRTH HISTORY ☐ Don't know birth history

Birth Hospital: ____________________________ Birth Wt: ______

Was the baby born at term? ______ Early? ______ Late? ______

If early, how many weeks' gestation? ________________________

Did mother have any illness or problem with her pregnancy?
☐ Yes ☐ No Explain: ____________________________________

During pregnancy, did mother
Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No
Use drugs or medications? ☐ Yes ☐ No
What? ____________________________ When? ______________

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ____

Did your baby have any problems right after birth?
☐ Yes ☐ No Explain: __________________________________

Was initial feeding: ☐ Breast? ☐ Bottle?

Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain: __________________________________

GENERAL (DK – don't know)

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain: ______________________

Does your child have any serious illness or medical condition? ☐ Yes ☐ No ☐ DK Explain: ______________________

Has your child had serious injuries or accidents? ☐ Yes ☐ No ☐ DK Explain: ______________________

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain: ______________________

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain: ______________________

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No ☐ DK Explain: ______________________

BIOLOGICAL FAMILY HISTORY (DK – don't know)

Have any family members had the following:

Childhood Hearing Loss ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Nasal Allergies ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Asthma ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Tuberculosis ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Heart Disease (before 55 years old) ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

High blood pressure (before 55 years old) ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

High cholesterol or takes cholesterol medication ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Anemia ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Bleeding disorder ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Dental Decay ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Cancer (before 55 years old) ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Liver disease ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Kidney disease ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Diabetes (before 55 years old) ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________

Please complete backside →

Bed-wetting (after 10 years old) ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Obesity ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Epilepsy or convulsions ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Alcohol abuse ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Drug abuse ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Mental illness / Depression ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Developmental Disability ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Immune problems, HIV, or AIDS ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Tobacco Use ☐ Yes ☐ No ☐ DK Who: ____________ Comments: ________________________
Additional family history: ____
____

PAST HISTORY (DK – don't know)

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

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

(For girls) Problems with her periods? ☐ Yes ☐ No ☐ DK Explain: ____________________________________

Has had first period ☐ Yes ☐ No Age of first period ____________

Any other significant problem: ____
____