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Initial History Questionnaire

Name: ____ ID Number: _______________________

Birth Date: ________________ Age:_________ ☐ M ☐ F

Form Completed By: __________________________________ Date Completed: __________________

Illness/Injuries

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

Does your child have a serious illness or medical condition? ☐ Yes ☐ No Explain: ____

Does your child have, or has he/she ever had:
Any chronic or recurrent skin problem (acne, eczema, etc.) ☐ Yes ☐ No Explain: ____

Use of alcohol or drugs ☐ Yes ☐ No Explain: ____

Nasal allergies ☐ Yes ☐ No Explain: ____

Anemia or bleeding problem ☐ Yes ☐ No Explain: ____

Asthma, bronchitis, bronchiolitis, or pneumonia ☐ Yes ☐ No Explain: ____

Bed-wetting (after 5 years old) ☐ Yes ☐ No Explain: ____

Bladder or kidney infection ☐ Yes ☐ No Explain: ____

Blood transfusion ☐ Yes ☐ No Explain: ____

Chickenpox ☐ Yes ☐ No Explain: ____

Constipation requiring doctor visits ☐ Yes ☐ No Explain: ____

Convulsions or other neurologic problem ☐ Yes ☐ No Explain: ____

Diabetes ☐ Yes ☐ No Explain: ____

Frequent ear infections ☐ Yes ☐ No Explain: ____

Problems with ears or hearing ☐ Yes ☐ No Explain: ____

Problems with eyes or vision ☐ Yes ☐ No Explain: ____

Frequent abdominal pain ☐ Yes ☐ No Explain: ____

Frequent headaches ☐ Yes ☐ No Explain: ____

Any heart problem or heart murmur ☐ Yes ☐ No Explain: ____

Thyroid or other endocrine problem ☐ Yes ☐ No Explain: ____

Any other significant problem ☐ Yes ☐ No Explain: ____

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

Surgery/Hospitalization/Past Medical History

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

Is your child allergic to any medicines or drugs? ☐ Yes ☐ No Explain: ____
Please list any medications or vitamins your child takes:_________________________ ____

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

Is your child followed by any specialist? ☐ Yes ☐ No Explain: ____

(For girls) OB-GYN

Has she started her menstrual periods? ☐ Yes ☐ No Explain: ____

Are there problems with her periods? ☐ Yes ☐ No Explain: ____

Birth History

Was the baby born at term? ☐ Yes ☐ No ☐ Early? ☐ Late?

If early, how many weeks gestation? ____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? ____

Birth Weight: __________________

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? ____

Family History

List all blood relatives of your child who have had the following-use abbrev. (F) Father, (M) Mother, (B) Brother, (S) Sister, (MM) Mother's Mother, (MF) Mother's Father, (Father's Mother), (FF) Father's Father, (A) Aunt, (U) Uncle, (C) Cousin

Condition	Yes/No	Who	Comments
Immune problems, HIV, or AIDS	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Alcohol abuse	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Nasal Allergies	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Anemia	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Asthma	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Bed-wetting (after 10 years old)	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Birth defects	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Bleeding disorder	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Cancer	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Diabetes Before Age 20	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Diabetes After Age 20	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Drug abuse	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Epilepsy or convulsions	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Deafness	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Heart disease (before 50 years old)	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
High cholesterol	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
High blood pressure (before 50yrs old)	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Kidney disease	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Liver disease	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Mental illness	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________
Mental retardation	☐ Yes ☐ No	Who:_______________	Comments: ___________________________________

Migraines	☐ Yes ☐ No	Who:______________	Comments: ________________________________
Scoliosis	☐ Yes ☐ No	Who:______________	Comments: ________________________________
Thyroid disorder	☐ Yes ☐ No	Who:______________	Comments: ________________________________
Tuberculosis	☐ Yes ☐ No	Who:______________	Comments: ________________________________
Additional family history	☐ Yes ☐ No	Who:______________	Comments: ________________________________

Social History/Home Environment

Mother's occupation:____

Father's occupation:____

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

Name	**Relationship to Child**	**Birthdate**	**Health Problems**
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________
__________________	_____________________	_________	__________________________

What is the water source in the home? ____

Does your child attend daycare? ☐ Yes ☐ No
If Yes, how many days/hours per week? ____

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?____

____

Does your child always wear a seat belt? ☐ Yes ☐ No Explain:____

Does your child wear a bike helmet? ☐ Yes ☐ No Explain:____

Are there smoke alarms in the home? ☐ Yes ☐ No Explain:____

Are there carbon monoxide detectors in the home? ☐ Yes ☐ No Explain: ____

Are there guns in the home? ☐ Yes ☐ No Explain:____

If yes, are they locked? ☐ Yes ☐ No Explain:____

Is your child exposed to smoke in the home? ☐ Yes ☐ No Explain:____

Are there pets in the home? ☐ Yes ☐ No Explain:____

Does your child participate in any extracurricular activities? ☐ Yes ☐ No Explain: ________________________________

Development

Are you concerned about your child's:
Attention span? ☐ Yes ☐ No Explain:____

Mental or emotional development? ☐ Yes ☐ No Explain:____

Physical development? ☐ Yes ☐ No Explain:____

What grade and school is your child currently in? ____

If your child is in school:
How is his/her behavior in school?____

____

How is he/she doing in academic subjects?____

____

Is he/she in special or resource classes?____

____

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

____