



# Initial History Questionnaire

Form completed by \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_

DOB \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

## HOUSEHOLD

Name	Relationship To child	Birth Date	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/parents not in the home? \_\_\_\_\_

## BIRTH HISTORY

Birth weight \_\_\_\_\_

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 (please circle):  
 Smoke \_\_\_\_\_ Drink Alcohol \_\_\_\_\_  
 use drugs or medications  
 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 hospital?  
 \_\_\_ Yes \_\_\_ No Explain \_\_\_\_\_

## GENERAL

(please circle):

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

(please circle):

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

Are you concerned about your child's mental/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 in school? \_\_\_\_\_

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: \_\_\_\_\_

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**FAMILY HISTORY**

(please circle):

Have any family members had the following:

Deafness	Yes	No	Who_____	Comments_____
Nasal Allergies	Yes	No	Who_____	Comments_____
Asthma	Yes	No	Who_____	Comments_____
Tuberculosis	Yes	No	Who_____	Comments_____
Heart disease (before 50 yrs old)	Yes	No	Who_____	Comments_____
High blood pressure (before 50 yrs old)	Yes	No	Who_____	Comments_____
High cholesterol	Yes	No	Who_____	Comments_____
Anemia	Yes	No	Who_____	Comments_____
Bleeding disorder	Yes	No	Who_____	Comments_____
Liver disease	Yes	No	Who_____	Comments_____
Kidney disease	Yes	No	Who_____	Comments_____
Diabetes (before 50 yrs old)	Yes	No	Who_____	Comments_____
Bed-wetting (after 10 yrs old)	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	Yes	No	Who_____	Comments_____
Mental retardation	Yes	No	Who_____	Comments_____
Immune problems, HIV, or AIDS	Yes	No	Who_____	Comments_____

Additional family history:\_\_\_\_\_

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**PAST HISTORY**

(please circle):

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

Chickenpox	Yes	No	Who_____	Comments_____
Frequent ear infections	Yes	No	Who_____	Comments_____
Problems with ears or hearing	Yes	No	Who_____	Comments_____
Nasal allergies	Yes	No	Who_____	Comments_____
Problems with eyes or vision	Yes	No	Who_____	Comments_____
Asthma, bronchitis, pneumonia	Yes	No	Who_____	Comments_____
Any heart problem or murmur	Yes	No	Who_____	Comments_____
Anemia or bleeding problem	Yes	No	Who_____	Comments_____
Blood transfusion	Yes	No	Who_____	Comments_____
Frequent abdominal pain	Yes	No	Who_____	Comments_____
Constipation requiring doctor visits	Yes	No	Who_____	Comments_____
Bladder or kidney infection	Yes	No	Who_____	Comments_____
Bed-wetting (after 5 yrs old)	Yes	No	Who_____	Comments_____
For girls: Has she started her menstrual periods?	Yes	No	Who_____	Comments_____
Are there problems with her periods?	Yes	No	Who_____	Comments_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	Yes	No	Who_____	Comments_____
Frequent headaches	Yes	No	Who_____	Comments_____
Convulsions or other neurological problems	Yes	No	Who_____	Comments_____
Diabetes	Yes	No	Who_____	Comments_____
Thyroid or other endocrine system	Yes	No	Who_____	Comments_____
Any other significant problem	Yes	No	Who_____	Comments_____
Use of alcohol or drugs	Yes	No	Who_____	Comments_____