Initial History Questionnaire

Patient Name: _____ Date of Birth: _____ Sex: M / F

Form completed by: _____ Date completed: _____

Please list family members

Name	Relationship to child	Birth date	Health Problems
	Mother		
	Father		
	Sibling		

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

Parents are married / divorced / other _____

What is the child's living situation if **not** with both biological parents?

___ Lives with adoptive parents ___ Joint custody ___ Single custody (which parent)_____ or ___ Lives with Foster family

If one or both of the parents are not living in the home, how often does the child see the parent(s) not living in the home? _____

Are there any smokers in the house? Yes / No Does the patient smoke? Yes / No / Quit What was the age of onset of smoking? _____

Birth History: ____ Unknown

Birth weight _____ Was the baby born at term? _____ or _____weeks.

Was there any prenatal complications? ___ Yes ___ No, Explain _____ _____

During pregnancy did mother Use tobacco? ___yes ___ no. Drink alcohol? ___ yes ___ no. Take prenatal vitamins ___yes ___ no

Was initial feeding ___formula ___Breast milk, How long breastfed? _____

Did your baby go home with mother from the hospital? ___yes ___no explain_____

General History: (DK = Don't Know)

Do you consider your child to be in good health? ___ yes ___ no ___ DK Explain_____

Does your child have any serious illnesses or medial conditions? ___ 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 medicine or drugs? ___ yes ___ no ___ DK Explain_____

Do you feel your family has enough to eat? ___ yes ___ no ___ DK Explain_____

<u>Biological Family</u> History **(DK = Don't Know)**

Has any family members had the following? Who **M** = Mother, **F** = Father, **S**=Sibling, **MGM** = Maternal Grandmother, **PGF** = Paternal Grandfather, ect.

Alcohol abuse ___ yes ___ no ___ DK Who _____ Comments_____

Anemia ___ yes ___ no ___ DK Who _____ Comments_____

Asthma ___ yes ___ no ___ DK Who _____ Comments_____

Bed-wetting (after 10 years old) ___ yes ___ no ___ DK Who _____ Comments_____

Birth defects ___ yes ___ no ___ DK Who _____ Comments_____

Bleeding disorder ___ yes ___ no ___ DK Who _____ Comments_____

Cancer (before 55 years old) ___ yes ___ no ___ DK Who _____ Comments_____

Childhood hearing loss ___ yes ___ no ___ DK Who _____ Comments_____

Dental Decay ___ yes ___ no ___ DK Who _____ Comments_____

History continued on other side. Please complete both sides of this page.

Developmental disability ___ yes ___ no ___ DK Who _____ Comments_____
Diabetes (before 55 years old) ___ yes ___ no ___ DK Who _____ Comments_____
Drug abuse ___ yes ___ no ___ DK Who _____ Comments_____
Heart disease (before 55 years) ___ yes ___ no ___ DK Who _____ Comments_____
High cholesterol/takes med ___ yes ___ no ___ DK Who _____ Comments_____
Immune problems, HIV, or AIDS ___ yes ___ no ___ DK Who _____ Comments_____
Kidney disease ___ yes ___ no ___ DK Who _____ Comments_____
Learning problems/ADHD ___ yes ___ no ___ DK Who _____ Comments_____
Liver disease ___ yes ___ no ___ DK Who _____ Comments_____
Mental illness/depression ___ yes ___ no ___ DK Who _____ Comments_____
Migraine ___ yes ___ no ___ DK Who _____ Comments_____
Obesity ___ yes ___ no ___ DK Who _____ Comments_____
Nasal allergies ___ yes ___ no ___ DK Who _____ Comments_____
Seizure disorder ___ yes ___ no ___ DK Who _____ Comments_____
Thyroid disease ___ yes ___ no ___ DK Who _____ Comments_____
Tobacco use ___ yes ___ no ___ DK Who _____ Comments_____
Tuberculosis ___ yes ___ no ___ DK Who _____ Comments_____

Additional family history _____

Past History of the <u>patient</u> **(DK= Don't Know)**

Does your child have, or has your child ever had.

ADHD/anxiety/mood problems/depression ___ yes ___ no ___ DK Explain _____
Anemia or bleeding problem ___ yes ___ no ___ DK Explain _____
Any heart problem or heart murmur ___ yes ___ no ___ DK Explain _____
Asthma, bronchitis, or pneumonia ___ yes ___ no ___ DK Explain _____
Bed-wetting (after 5 years old) ___ yes ___ no ___ DK Explain _____
Birth defects ___ yes ___ no ___ DK Explain _____
Blood transfusion ___ yes ___ no ___ DK Explain _____
Cancer ___ yes ___ no ___ DK Explain _____
Chemotherapy ___ yes ___ no ___ DK Explain _____
Chickenpox ___ yes ___ no ___ DK Explain _____
Chronic or recurrent skin problems ___ yes ___ no ___ DK Explain _____
Constipation requiring clinic visits ___ yes ___ no ___ DK Explain _____
Convulsions or other neurologic problems ___ yes ___ no ___ DK Explain _____
Dental decay ___ yes ___ no ___ DK Explain _____
Developmental delay ___ yes ___ no ___ DK Explain _____
Diabetes ___ yes ___ no ___ DK Explain _____
Frequent abdominal pain ___ yes ___ no ___ DK Explain _____
Frequent ear infections ___ yes ___ no ___ DK Explain _____
Frequent headaches ___ yes ___ no ___ DK Explain _____
High blood pressure ___ yes ___ no ___ DK Explain _____
History of family violence ___ yes ___ no ___ DK Explain _____
History of serious injury/fracture/concussion ___ yes ___ no ___ DK Explain _____
HIV ___ yes ___ no ___ DK Explain _____
Kidney disease or urologic malformations ___ yes ___ no ___ DK Explain _____
Learning Problem ___ yes ___ no ___ DK Explain _____
Malignancy/bone marrow transplant ___ yes ___ no ___ DK Explain _____
Metabolic/Genetic disorders ___ yes ___ no ___ DK Explain _____
Nasal allergies ___ yes ___ no ___ DK Explain _____
Obesity ___ yes ___ no ___ DK Explain _____
Organ transplant ___ yes ___ no ___ DK Explain _____
Pregnancy ___ yes ___ no ___ DK Explain _____
(for girls) Problems with periods ___ yes ___ no ___ DK Explain _____
Has had first period ___ yes ___ no Age of first period _____
Problems with ears or hearing ___ yes ___ no ___ DK Explain _____
Problems with eyes or vision ___ yes ___ no ___ DK Explain _____
Recurrent urinary tract infections ___ yes ___ no ___ DK Explain _____
Sexually transmitted diseases ___ yes ___ no ___ DK Explain _____
Sleep problems/snoring ___ yes ___ no ___ DK Explain _____
Thyroid or other endocrine problem ___ yes ___ no ___ DK Explain _____
Tobacco use ___ yes ___ no ___ DK Explain _____
Use of alcohol or drugs ___ yes ___ no ___ DK Explain _____

Any other significant problems or things you would like us to know_____

_____

History continued on other side. Please complete both sides of this page.