INITIAL HISTORY QUESTIONNAIRE

Name: ___________________________
Date of birth: ___________ Sex: ___
Patient's age: ___________
Previous physician: ________________

Form completed by: ________________________

Date completed: ________________

HOUSEHOLD

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

Name:	Relationship to child:	Date of Birth:	Health problems:

If the parents do not live together or if the child does not live with the parents, what is the child's custody status?
____

BIRTH HISTORY

Birth weight ____________________

Was the baby born at term? ______ Early? ______

If early, how many weeks gestation? ___________

Did mother have any illnesses or problems during her pregnancy? ___ Yes ___ No
If yes, please explain ___________________

During pregnancy, did mother
Drink alcohol? ___ Yes ___No
Smoke? ___ Yes ___ No
Use drugs or medication? ___ Yes ___ No
What and when? ___________________________

Was the delivery Vaginal ___ Cesarean ___

If cesarean, why? __________________________

Did your baby have any problems right after birth?
___ Yes ___ No If yes, please explain ______
____

Was initial feeding: Breast ___ Bottle ___

Did your baby go home with mother from the hospital? ___ Yes ___ No
If no, please explain ________________________
____

GENERAL

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

Does your child have any serious medical conditions? ___ Yes ___ No Explain _________________

Has your child had any 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 medications 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 emotional development? ___ Yes ___ No Explain ___________

How is your child doing academically in school? ____

Has your child ever repeated or failed a grade? ____

How is your child's behavior in school? ____

FAMILY HISTORY

Have any family members had the following:

Deafness	___ Yes	___ No	Who? ________	Comments ___________________
Nasal allergies	___ Yes	___ No	Who? ________	Comments ___________________
Tuberculosis	___ Yes	___ No	Who? ________	Comments ___________________
Asthma	___ Yes	___ No	Who? ________	Comments ___________________
Heart disease (prior to 50 years old)	___ Yes	___ No	Who? ________	Comments ___________________
High blood pressure (prior to 50 years)	___ 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 (prior to 50 years old)	___ Yes	___ No	Who? ________	Comments ___________________
Bedwetting (after 10 years old)	___ Yes	___ No	Who? ________	Comments ___________________
Epilepsy or seizures	___ 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 ____

____

PAST MEDICAL HISTORY

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

Chickenpox	___ Yes	___ No	When? _______________________________
Frequent ear infections	___ Yes	___ No	Explain _______________________________
Problems with ears or hearing	___ Yes	___ No	Explain _______________________________
Nasal allergies	___ Yes	___ No	Explain _______________________________
Problems with eyes or vision	___ Yes	___ No	Explain _______________________________
Asthma, bronchitis or pneumonia	___ Yes	___ No	Explain _______________________________
Any heart problem or heart murmur	___ Yes	___ No	Explain _______________________________
Anemia or bleeding problem	___ Yes	___ No	Explain _______________________________
Blood transfusion	___ Yes	___ No	Explain _______________________________
Frequent abdominal pain	___ Yes	___ No	Explain _______________________________
Constipation requiring doctor's visit	___ Yes	___ No	Explain _______________________________
Bladder or kidney infection	___ Yes	___ No	Explain _______________________________
Bed-wetting (after 5 years old)	___ Yes	___ No	Explain _______________________________
(For girls) Has she started her menses?	___ Yes	___ No	When? _______________________________
(For girls) Any problems with her periods?	___ Yes	___ No	Explain _______________________________
Any chronic skin conditions (acne or eczema)	___ Yes	___ No	Explain _______________________________
Frequent headaches	___ Yes	___ No	Explain _______________________________
Convulsions or neurological problems	___ Yes	___ No	Explain _______________________________
Diabetes	___ Yes	___ No	Explain _______________________________
Thyroid or other endocrine problem	___ Yes	___ No	Explain _______________________________
Any other significant problem	___ Yes	___ No	Explain _______________________________
Use of alcohol or drugs	___ Yes	___ No	Explain _______________________________

MEDICATIONS

Please list any medications your child takes on a daily basis: ____

Please list any medications your child has taken on a daily basis in the past: __________________________________