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INITIAL HISTORY QUESTIONNAIRE

Patient Name: _____ DOB: _____

Previously Seen / Treated by: _____

HOUSEHOLD

Child's Name	Relation	Age	Medical Problem
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Any siblings that don't live at home? Where?
_____

If mother & father don't live together, or child doesn't live at home, what is the child's custody status?
_____

How often does the child see the other parent?
_____

BIRTH HISTORY

Birth Weight: _____ Was the baby born on time? ☐ Yes ☐ No ; If early/late, how many weeks gestation?_____

Any problems with the pregnancy (hospitalizations, had to take medicines, etc), ? ☐ Yes ☐ No _____

Any medicines during pregnancy? ☐ Yes ☐ No Which ones: _____

When mother was pregnant, did she: ☐ Drink alcohol ☐ Smoke ☐ Use drugs? _____

Was the delivery ☐ vaginal OR ☐ c-section ; If caesarian, why? _____

Did your baby have any problems right after birth? ☐ Yes ☐ No _____

Did your baby go home with mother from the hospital? ☐ Yes ☐ No _____

GENERAL

Do you consider your child to be in good health? ☐ Yes ☐ No EXPLAIN: _____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No EXPLAIN: _____

Has your child had serious injuries or accidents? ☐ Yes ☐ No EXPLAIN: _____

Has your child had any surgeries? ☐ 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

Are you concerned about:

Your child's physical development? ☐ Yes ☐ No EXPLAIN: _____

Your child's mental/emotional development? ☐ Yes ☐ No EXPLAIN: _____

Your child's attention span? ☐ Yes ☐ No EXPLAIN: _____

If your child is in school:

Are you worried about their behavior in school? ☐ Yes ☐ No EXPLAIN: _____

Has he/she failed or repeated a grade? ☐ Yes ☐ No EXPLAIN: _____

How is he/she doing in academic subjects (English, Math)? ☐ Yes ☐ No EXPLAIN: _____

Is he/she in special or resource classes? ☐ Yes ☐ No EXPLAIN: _____

FAMILY HISTORY

Have any family members had the following:

Deafness or visual problems	☐ Yes ☐ No	Who: _____	Comments: _____
Nasal allergies	☐ Yes ☐ No	Who: _____	Comments: _____
Asthma	☐ Yes ☐ No	Who: _____	Comments: _____
Tuberculosis	☐ Yes ☐ No	Who: _____	Comments: _____
Heart disease (before age 50)	☐ Yes ☐ No	Who: _____	Comments: _____
High blood pressure (before age 50)	☐ Yes ☐ No	Who: _____	Comments: _____
High cholesterol	☐ Yes ☐ No	Who: _____	Comments: _____
Anemia or bleeding disorder	☐ Yes ☐ No	Who: _____	Comments: _____
Liver disease	☐ Yes ☐ No	Who: _____	Comments: _____
Kidney disease	☐ Yes ☐ No	Who: _____	Comments: _____
Diabetes	☐ Yes ☐ No	Who: _____	Comments: _____
Bed-wetting (after 10 years old)	☐ Yes ☐ No	Who: _____	Comments: _____
Epilepsy or convulsions	☐ Yes ☐ No	Who: _____	Comments: _____
Alcohol abuse / drug abuse	☐ Yes ☐ No	Who: _____	Comments: _____
Mental illness (psychiatric)	☐ Yes ☐ No	Who: _____	Comments: _____
Mental retardation	☐ Yes ☐ No	Who: _____	Comments: _____
Immune problems	☐ Yes ☐ No	Who: _____	Comments: _____
Gastrointestinal disease	☐ Yes ☐ No	Who: _____	Comments: _____
Cancer	☐ Yes ☐ No	Who: _____	Comments: _____

Additional Family History: _____

PATIENT'S PAST MEDICAL HISTORY

Does your child have/ever had any of the following:

Surgery	☐ Yes ☐ No	When/Type: _____
Chicken Pox	☐ Yes ☐ No	When: _____
Frequent headaches	☐ Yes ☐ No	Explain: _____
Problems with hearing or seeing	☐ Yes ☐ No	Explain: _____
Frequent ear or throat infections	☐ Yes ☐ No	Explain: _____
Nasal allergies/Allergies	☐ Yes ☐ No	Explain: _____
Asthma, Bronchiolitis, Pneumonia	☐ Yes ☐ No	Explain: _____
Any heart problem, heart murmur	☐ Yes ☐ No	Explain: _____
Anemia or bleeding problem	☐ Yes ☐ No	Explain: _____
Blood transfusions	☐ Yes ☐ No	When/Circumstance: _____
Diarrhea/vomiting/constipation	☐ Yes ☐ No	Explain: _____
Frequent abdominal pain	☐ Yes ☐ No	Explain: _____
Bladder or kidney infection	☐ Yes ☐ No	When: _____
Bed-wetting after 5 years old	☐ Yes ☐ No	Explain: _____
(FOR GIRLS) started menstruation	☐ Yes ☐ No	When: _____
(FOR GIRLS) problems with periods	☐ Yes ☐ No	Explain: _____
Chronic or recurrent skin problems	☐ Yes ☐ No	Explain: _____
Neurologic problems (seizures)	☐ Yes ☐ No	Explain: _____
Endocrine problems (thyroid, diabetes)	☐ Yes ☐ No	Explain: _____
Use of alcohol or drugs	☐ Yes ☐ No	Explain: _____

Other problems: _____