Initial History Questionnaire

PATIENT INFORMATION

Child's Name: ______________________ Date of Birth: ______________

Home Address: ____

Home Phone: ______________ Cell Phone: ______________

Form Completed By: ______________________ Date Completed: ______________

HOUSEHOLD – Please list all occupants living in the child's home, their relationship to the child, and their age:

____

____

____

BIRTH HISTORY – (Under 5 years)

Birth Weight: __________ lbs. __________ oz. Date of adoption *(if applicable)*: ______________

Was the baby born at: ☐ Early ☐ Term ☐ Late *If early,* how many weeks gestation? __________

Type of Delivery: ☐ Vaginal ☐ Cesarean If cesarean, why? ______________

Were there any problems pertaining to the pregnancy or birth? ☐ Yes ☐ No *(If yes, please explain)*

____

During pregnancy, did the mother (*Check all that apply*): ☐ Smoke ☐ Drink Alcohol ☐ Use drugs or medications

GENERAL – (if applicable)

Do you consider your child to be in good health? ☐ Yes ☐ No (*Please explain*): ______________

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No (*Please explain*): ______________

Has your child had serious injuries or accidents? ☐ Yes ☐ No (*Please explain*): ______________

Has your child had any surgeries? ☐ Yes ☐ No (*Please explain*): ______________

Has your child ever been hospitalized? ☐ Yes ☐ No (*Please explain*): ______________

Is your child allergic to any medicine or drugs? ☐ Yes ☐ No (*Please explain*): ______________

Does your child take any medications on a regular basis? ☐ Yes ☐ No (*Please explain*): ______________

DEVELOPMENT – (if applicable)

Name of school (or daycare): ____________________ Grade: ________

How is his/her behavior in school? ____________________

Has he or she repeated a grade in school? ☐ Yes ☐ No If yes, what grade(s)? ________

How is he or she doing in academic subjects? ____________________

Is he or she in special or resource classes? ☐ Yes ☐ No

Are you concerned about your child's physical development? ☐ Yes ☐ No *(please explain)*
____

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No *(please explain)*
____

Are you concerned about your child's attention span? ☐ Yes ☐ No *(please explain)*
____

FAMILY HISTORY – Have any family members had the following:

Condition	Yes	No
Deafness	☐Yes	☐No
Allergies (food or environmental)	☐Yes	☐No
Asthma	☐Yes	☐No
Tuberculosis	☐Yes	☐No
Heart Disease or Sudden Death	☐Yes	☐No
High Blood Pressure (before age 50)	☐Yes	☐No
High Cholesterol	☐Yes	☐No
Anemia/Bleeding Disorder	☐Yes	☐No
Liver/Kidney Disease	☐Yes	☐No
Diabetes (before age 50)	☐Yes	☐No
Epilepsy or Convulsions	☐Yes	☐No
Alcohol/Drug Abuse	☐Yes	☐No
Mental Illness/Depression	☐Yes	☐No
Mental Retardation	☐Yes	☐No
Immune Problems, HIV/AIDS	☐Yes	☐No
Cancer	☐Yes	☐No
Gastrointestinal Problems	☐Yes	☐No
Blood Disorders	☐Yes	☐No

PAST MEDICAL HISTORY – Does your child have *or* has your child ever had:

Condition	Yes	No
Allergies (food, drug, or environmental)	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Bedwetting	☐ Yes	☐ No
Bladder or Kidney Problems	☐ Yes	☐ No
Blood Disorders	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Constipation	☐ Yes	☐ No
Congenital Anomalies	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Developmental or Behavior Disorders	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No
Muscle, Joint, or Bone Problems	☐ Yes	☐ No
Seizures/Epilepsy	☐ Yes	☐ No
Serious Injuries or Illnesses	☐ Yes	☐ No
Sickle Cell	☐ Yes	☐ No
Skin Problems	☐ Yes	☐ No
Thyroid Problems	☐ Yes	☐ No
Immune Problems, HIV/AIDS	☐ Yes	☐ No
Vision or Eye Problems	☐ Yes	☐ No

If Yes, please explain: ____________________

ADDITIONAL HISTORY

Question	Yes	No
Does your child smoke cigarettes or use tobacco?	☐ Yes	☐ No
Are firearms present in the home that the child resides?	☐ Yes	☐ No
Are there working smoke/carbon monoxide detectors in the home?	☐ Yes	☐ No
Are there pets in the home?	☐ Yes	☐ No