APC Health – Pediatric Department Initial History Questionnaire

If possible attach a copy of your child's immunization record and return with this form at your appointment.

Child's Name	Date of Birth	Age
Address	Form Completed By	Date Completed
Home Phone	Cell Phone	Work Phone

Household - please list all those living in the child's home

Name	Relationship to child	Age	Occupation	Health Problems

Are there siblings not listed? If so, please list their name and ages.

_____

_____

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

_____

Birth History

Birth weight _____lbs. _____oz.
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: Smoke? ☐ Yes ☐ No Drink alcohol? ☐ Yes ☐ No
Use drugs or medications? ☐ Yes ☐ No What? And When?

_____

Date of adoption (if applicable)_____ Was the delivery ☐ Vaginal? ☐ Cesarean?
If cesarean, why? _____

_____

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

_____

Was initial feeding ☐ Breast? ☐ Bottle?
Did baby go home with mother from the hospital?
☐ Yes ☐ No Explain_____

General (if applicable)

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 been hospitalized? ☐ Yes ☐ No Explain_____
Is your child allergic to any medicine or drugs? ☐ Yes ☐ No Explain_____
Does your child take any medications on a regular basis? ☐ Yes ☐ No Explain_____

Development (if applicable)

Name of school (or daycare) and grade in school_____
How is his/her behavior in school? _____
Has he/she repeated a grade in school? _____
How is he/she doing in academic subjects? _____
Is he/she in special or resource classes? _____

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain_____
Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No Explain_____
Are you concerned about your child's attention span? ☐ Yes ☐ No Explain_____

Clinician Signature_____

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Family History – have any family members had the following: ☐ Unknown

Deafness ☐ Yes ☐ No Who_____ Comments_____

Allergies (food or environmental) ☐ Yes ☐ No Who_____ Comments_____

Asthma ☐ Yes ☐ No Who_____ Comments_____

Tuberculosis ☐ Yes ☐ No Who_____ Comments_____

Heart disease or sudden death (before 50 years old) ☐ Yes ☐ No Who_____ Comments_____

High blood pressure (before 50 years old) ☐ Yes ☐ No Who_____ Comments_____

High cholesterol ☐ Yes ☐ No Who_____ Comments_____

Anemia/Bleeding disorder ☐ Yes ☐ No Who_____ Comments_____

Liver/Kidney disease ☐ Yes ☐ No Who_____ Comments_____

Diabetes (before 50 years old) ☐ Yes ☐ No Who_____ Comments_____

Epilepsy or convulsions ☐ Yes ☐ No Who_____ Comments_____

Alcohol/Drug abuse ☐ Yes ☐ No Who_____ Comments_____

Mental illness/depression ☐ Yes ☐ No Who_____ Comments_____

Mental retardation ☐ Yes ☐ No Who_____ Comments_____

Immune problems, HIV or AIDS ☐ Yes ☐ No Who_____ Comments_____

Cancer ☐ Yes ☐ No Who_____ Comments_____

Gastrointestinal problems ☐ Yes ☐ No Who_____ Comments_____

Past History (if applicable) – Does your child have or has he/she ever had:

Chickenpox ☐ Yes ☐ No When_____

Frequent ear infections/hearing loss ☐ Yes ☐ No Explain_____

Allergies (food or environmental) ☐ Yes ☐ No Explain_____

Problems with eyes or vision ☐ Yes ☐ No Explain_____

Asthma, bronchitis, bronchiolitis or pneumonia ☐ Yes ☐ No Explain_____

Any heart problem or heart murmur ☐ Yes ☐ No Explain_____

Anemia or bleeding problem ☐ Yes ☐ No Explain_____

Frequent abdominal pain/constipation ☐ 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 menstrual period ☐ Yes ☐ No When and list any problems_____

Any chronic or recurrent skin problem ☐ Yes ☐ No Explain_____

Frequent headaches ☐ Yes ☐ No Explain_____

Convulsions or other neurological problems ☐ Yes ☐ No Explain_____

Diabetes ☐ Yes ☐ No Explain_____

Thyroid or other endocrine problems ☐ Yes ☐ No Explain_____

Alcohol/Drug use ☐ Yes ☐ No Explain_____

Any other significant problems ☐ Yes ☐ No Explain_____

Home Environment – Please check all that are in the household where the child resides:

☐ Smokers
☐ Guns/Firearms
☐ Smoke detectors
☐ Carbon monoxide detectors
☐ Pets_____ (type)