

## 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 \_\_\_\_\_

**Biological Family 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 patient**

(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 \_\_\_\_\_