

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 _____