INITIAL HISTORY QUESTIONNAIRE

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Patient Name _____ **Birth Date:** _____ **Age:** _____ ☐ **Female** ☐ **Male**

Person completing the form _____ **Date Completed:** _____

Household

Please list all those living in the child's home

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live: _____

What is the child's living situation if not with both biological parents?

☐ Lives with adoptive parents ☐ Joint custody

☐ Lives with foster family ☐ Single custody

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History

Birth History Unknown

Birth Weight _____ Was the baby born at term? ☐ Yes ☐ No _____ Weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

Was a NICU stay required? ☐ Yes ☐ No Explain _____

During pregnancy, did mother:

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What _____ When _____

Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, why? _____

Initial feeding ☐ Formula ☐ Breast Milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

General

DK Do Not Know

Do you consider your child to be in good health?	☐ Yes	☐ No	☐ DK	Explain _____
Does your child have any serious illness or medical 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

Have any family members had the following?

Childhood Hearing Loss	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Nasal Allergies	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Heart Disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
High Cholesterol/Takes Cholesterol Medication	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Anemia	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Bleeding Disorder	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Dental Decay	☐ Yes	☐ No	☐ DK	Who _____	Comments _____
Cancer	☐ Yes	☐ No	☐ DK	Who _____	Comments _____

(Biological Family History continued on other side.)

Biological Family History *(continued from front side)*

DK = Do Not Know

Liver Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Kidney Disease	☐ Yes	☐ No	☐ DK	Who		Comments	
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who		Comments	
Obesity	☐ Yes	☐ No	☐ DK	Who		Comments	
Epilepsy or Convulsions	☐ Yes	☐ No	☐ DK	Who		Comments	
Alcohol Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Drug Abuse	☐ Yes	☐ No	☐ DK	Who		Comments	
Mental Illness/Depression	☐ Yes	☐ No	☐ DK	Who		Comments	
Developmental Disability	☐ Yes	☐ No	☐ DK	Who		Comments	
Immune Problems, HIV or AIDs	☐ Yes	☐ No	☐ DK	Who		Comments	
Tobacco Use	☐ Yes	☐ No	☐ DK	Who		Comments	

Additional Family History _____

Past History

DK = Do Not Know

Does you child have, or has your child ever had:

Chickenpox	☐ Yes	☐ No	☐ DK	When	
Frequent Ear Infections	☐ Yes	☐ No	☐ DK	Explain	
Problems with Ears or Hearing	☐ Yes	☐ No	☐ DK	Explain	
Nasal Allergies	☐ Yes	☐ No	☐ DK	Explain	
Problems with Eyes or Vision	☐ Yes	☐ No	☐ DK	Explain	
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	☐ Yes	☐ No	☐ DK	Explain	
Any Heart Problem or Heart Murmur	☐ Yes	☐ No	☐ DK	Explain	
Anemia or Bleeding Problem	☐ Yes	☐ No	☐ DK	Explain	
Blood Transfusion	☐ Yes	☐ No	☐ DK	Explain	
HIV	☐ Yes	☐ No	☐ DK	Explain	
Organ Transplant	☐ Yes	☐ No	☐ DK	Explain	
Malignancy/Bone Marrow Transplant	☐ Yes	☐ No	☐ DK	Explain	
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain	
Frequent Abdominal Pain	☐ Yes	☐ No	☐ DK	Explain	
Constipation Requiring Doctor Visits	☐ Yes	☐ No	☐ DK	Explain	
Recurrent Urinary Tract Infections and Problems	☐ Yes	☐ No	☐ DK	Explain	
Congenital Cataracts/Retinoblastoma	☐ Yes	☐ No	☐ DK	Explain	
Metabolic/Genetic Disorders	☐ Yes	☐ No	☐ DK	Explain	
Cancer	☐ Yes	☐ No	☐ DK	Explain	
Kidney Disease or Urologic Malformations	☐ Yes	☐ No	☐ DK	Explain	
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain	
Sleep Problems; Snoring	☐ Yes	☐ No	☐ DK	Explain	
Chronic or Recurrent Skin Problems (e.g., acne, eczema)	☐ Yes	☐ No	☐ DK	Explain	
Frequent Headaches	☐ Yes	☐ No	☐ DK	Explain	
Convulsions or Other Neurologic Problems	☐ Yes	☐ No	☐ DK	Explain	
Obesity	☐ Yes	☐ No	☐ DK	Explain	
Diabetes	☐ Yes	☐ No	☐ DK	Explain	
Thyroid or Other Endocrine Problems	☐ Yes	☐ No	☐ DK	Explain	
High Blood Pressure	☐ Yes	☐ No	☐ DK	Explain	
History of Serious Injuries/Fractures/Concussions	☐ Yes	☐ No	☐ DK	Explain	
Use of Alcohol or Drugs	☐ Yes	☐ No	☐ DK	Explain	
Tobacco Use	☐ Yes	☐ No	☐ DK	Explain	
ADHD/Anxiety/Mood Problems/Depression	☐ Yes	☐ No	☐ DK	Explain	
Developmental Delay	☐ Yes	☐ No	☐ DK	Explain	
Dental Decay	☐ Yes	☐ No	☐ DK	Explain	
History of Family Violence	☐ Yes	☐ No	☐ DK	Explain	
Sexually Transmitted Infections	☐ 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 _____

Any Other Significant Problem _____