

Initial History Questionnaire

PARENTS NAMES _____

PHONE _____

FORM COMPLETED BY _____ DATE COMPLETED _____

BIRTH DATE _____ AGE _____

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 and ages and where they live. _____

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

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home? _____

Birth History

Birth weight _____

Was the delivery Vaginal? Cesarean?

Was the baby born at term? _____ Early? _____ Late? _____

If cesarean, why? _____

If early, how many weeks' gestation? _____

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?

Yes No Explain _____

Yes No Explain _____

During pregnancy, did mother

Smoke Yes No Drink alcohol Yes No

Use drugs or medications Yes No

What _____ When _____

Was initial feeding Breast? Bottle?

Did your baby go home with mother from the hospital?

Yes No Explain _____

General

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 ever been hospitalized?

Yes No Explain _____

Is your child allergic to any medicines or drugs?

Yes No Explain _____

Development

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 _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____



Family History *(ie., grandparents, aunts, uncles, cousins)*

Have any family members had the following:

Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Bed-wetting	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Birth Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Drug/Alcohol Addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Epilepsy or Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Gastrointestinal	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Hereditary Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
High cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Immune Problems, HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Mental Retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Other	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who?	_____	Comments _____

PAST HISTORY

Does your child have, or has ever had:

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Asthma, bronchitis or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Bladder or kidney infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
(For girls)				
Has she started menstrual periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When	_____
(For girls)				
Are there problems with her periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Convulsions or other neurologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Thyroid or other endocrine problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Any other significant problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____
Use of Alcohol or Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain	_____