

**ALLERGIES:**

# Initial History Questionnaire

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

Patient Name: \_\_\_\_\_

Parents Name \_\_\_\_\_

Phone: (H) \_\_\_\_\_

(W) \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

PCP \_\_\_\_\_

Record Id# \_\_\_\_\_

## Household

Please list all those living in the child's home.

| Name | Relationship to child | Birth date | Health problems |
|------|-----------------------|------------|-----------------|
|      | Mother                |            |                 |
|      | Father                |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |
|      |                       |            |                 |

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? \_\_\_\_\_

