



INITIAL HISTORY QUESTIONNAIRE

Patient Name _____

Birth Date: _____ Age: _____ Female Male

Person completing the form _____

Date Completed: _____

Household

Please list all those living in the child's home

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

Name	Relationship to Child	Birth Date	Health Problems

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

Was the delivery Vaginal Cesarean If cesarean, why? _____

Were there any prenatal or neonatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

Initial feeding Formula Breast Milk How long breastfed? _____

During pregnancy, did mother:

Use tobacco Yes No Drink alcohol Yes No

Did your baby go home with mother from the hospital?

Use drugs or medications Yes No Used prenatal vitamins

Yes No Explain _____

What _____ When _____

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?

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

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 your child have, or has your child ever had:

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