CHILDREN'S PEDIATRICS

Name
Date of Birth
Chart No.

Initial History Questionnaire

Household:

Please list those living in the child's home:

Name	Relationship to child	Birthdate	Health problems

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

_____

If the mother and father are not living together or if the 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: _____

❑ Vaginal Delivery? ❑ Cesarean Delivery? If cesarean, why? _____

Was the baby born at term? _____ Early? ___ Late? ___ If early, how many week's gestation? _____

Did your baby have any problems right after birth? ❑ Yes ❑ No Explain: _____

Did mother have prenatal care? __ _____

Did mother have any illness or problem with her pregnancy? ❑ Yes ❑ No Explain: _____

_____

During pregnancy, did mother: Smoke: ❑ Yes ❑ No

Drink alcohol: ❑ Yes ❑ No

Use drugs or medications: ❑ Yes ❑ No If yes, What: _____ When: _____

Was initial feeding: ❑ Breast? ❑ Bottle?

Did your baby go home with mother from the hospital? ❑ Yes ❑ No Explain: _____

General	Yes	No	Comments
Does your child have any serious illness or medical condition?	❑	❑	
Has your child had any serious injuries or accidents?	❑	❑	
Has your child had any surgery?	❑	❑	
Has your child ever been hospitalized?	❑	❑	
Is your child allergic to any medications or drugs?	❑	❑	
Development	❑	❑	
Does your child have physical developmental problems?	❑	❑	
Does your child have mental or emotional development problems?	❑	❑	
Does your child have problems with their attention span?	❑	❑	
If your child is in school:			
Does your child have behavior problems in school?	❑	❑	
Has he/she failed or repeated a grade in school?	❑	❑	
Does your child have academic problems in school?	❑	❑	
Is he/she in special or resource classes?	❑	❑	

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Family History

Have any family members had the following:	Yes	No	Who?
Deafness	❑	❑	
Nasal allergies	❑	❑	
Asthma	❑	❑	
Cancer	❑	❑	
Tuberculosis	❑	❑	
Heart disease (before 50 years old)	❑	❑	
High blood pressure (before 50 years old)	❑	❑	
High cholesterol	❑	❑	
Anemia	❑	❑	
Sickle cell	❑	❑	
Bleeding disorder	❑	❑	
Liver disease	❑	❑	
Kidney disease	❑	❑	
Diabetes (before 50 years old)	❑	❑	
Bed-wetting (after 10 years old)	❑	❑	
Epilepsy or convulsions	❑	❑	
Alcohol abuse	❑	❑	
Drug abuse	❑	❑	
Mental illness	❑	❑	
Mental retardation	❑	❑	
Immune problems, HIV or AIDS	❑	❑	
Glaucoma or blindness	❑	❑	
Additional family history	❑	❑	

Past History

Does your child have, or has he/she ever had?	Yes	No	Describe, if necessary
Chicken pox, measles, mumps or rubella	❑	❑	
Frequent ear infections	❑	❑	
Nasal allergies	❑	❑	
Problems with eyes or vision (wear glasses)	❑	❑	
Asthma, bronchitis, bronchiolitis or pneumonia	❑	❑	
Any heart problem or heart murmur	❑	❑	
Anemia or bleeding problem	❑	❑	
Blood transfusion	❑	❑	
Frequent abdominal pain	❑	❑	
Constipation requiring doctor visits	❑	❑	
Bladder or kidney infection	❑	❑	
Bed-wetting (after 5 years old)	❑	❑	
(For girls) Has she started her menstrual periods?	❑	❑	
(For girls) Are there problems with her periods?	❑	❑	
Any chronic or recurrent skin problem (acne, eczema, etc.)	❑	❑	
Frequent headaches	❑	❑	
Convulsions or other neurologic problem	❑	❑	
Diabetes	❑	❑	
Thyroid or other endocrine problem	❑	❑	
Delayed speech or speech problem	❑	❑	
Eating problems	❑	❑	
Dental disease or caries	❑	❑	
Any other significant problems?			

Signature	**Date** MM/DD/YY	**Time** 00:00 AM/PM
X	/ /	: