Initial History Questionaire

Name_____ Chart#_____
Home Phone #_____ Work#_____
Birthdate_____ Age_____ M F

Houshold

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, list their names, 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_____ Was the baby born term_____ Early?____ Late?_____
If early,how many weeks' gestation?_____
Was the delivery Vaginal / Cesarean?(circle) If cesarean, why_____
Did the mother have any illnesses or problem with her pregnancy? YES / NO Explain_____

During pregnancy, did the mother: Smoke YES / NO Drink alcohol YES / NO
Use drugs or medications YES / NO
If Yes, what_____ When_____
Did the baby have any problems right after birth? YES / NO Explain_____

Was initial feeding Breast / Bottle? (circle)
Did the baby go home with the mother from hospital? YES / NO Explain_____

General

Do you consider your child to be in good health? YES NO Explain_____
Does your child have any serious illnesses or medical conditions? YES NO Explain_____
Has your child had any serious injuries or accidents? YES NO Explain_____
Has your child ever had surgery? YES NO Explain_____
Has your child ever been hospitalized? YES NO Explain_____
Is your child allergic to any medications 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_____
Is your child in school:
How is his/her behavior in school?_____
Has he/she failed or repeated a grade level?_____
How is he/ she doing academically?_____
Is he/she in special needs or resource classes?_____

Family History

Have any family members had the following:

Deafness	YES	NO	Who_____	Comments_____
Nasal allergies	YES	NO	Who_____	Comments_____
Asthma	YES	NO	Who_____	Comments_____
Tuberculosis	YES	NO	Who_____	Comments_____
Heart disease (before 50 years old)	YES	NO	Who_____	Comments_____
High blood pressure (before 50 years old)	YES	NO	Who_____	Comments_____
High cholesterol	YES	NO	Who_____	Comments_____
Anemia	YES	NO	Who_____	Comments_____
Liver disease	YES	NO	Who_____	Comments_____
Kidney disease	YES	NO	Who_____	Comments_____
Diabetes (before 50 years old)	YES	NO	Who_____	Comments_____
Bed-wetting (after 10 years old)	YES	NO	Who_____	Comments_____
Epilepsy or convulsion	YES	NO	Who_____	Comments_____
Alcohol abuse	YES	NO	Who_____	Comments_____
Drug abuse	YES	NO	Who_____	Comments_____
Mental illness	YES	NO	Who_____	Comments_____
Mental retardation	YES	NO	Who_____	Comments_____
Immune problems, HIV or AIDS	YES	NO	Who_____	Comments_____

Additional Family History_____

Past History

Does your child have or have had the following:

Chickenpox	YES	NO	When_____
Frequent ear infections	YES	NO	Explain_____
Problems with ears / hearing	YES	NO	Explain_____
Nasal allergies	YES	NO	Explain_____
Problems with eyes / vision	YES	NO	Explain_____
Asthma,bronchitis, bronchiolitis, or pneumonia	YES	NO	Explain_____
Any heart problem or heart murmur	YES	NO	Explain_____
Anemia or bleeding problem	YES	NO	Explain_____
Blood transfusion	YES	NO	Explain_____
Constipation reqiring doctor visits	YES	NO	Explain_____
Frequent abdominal pain	YES	NO	Explain_____
Bladder or kidney infection	YES	NO	Explain_____
Bed-wetting (after 5 years old)	YES	NO	Explain_____
(Girls) Has she started menstrual period?	YES	NO	Explain_____
(Girls) Are there any problems with her periods?	YES	NO	Explain_____
Any chronic or recurrent skin problems (acne, eczema, etc.)	YES	NO	Explain_____
Frequent headaches	YES	NO	Explain_____
Convulsions or other neurologic problem	YES	NO	Explain_____
Diabetes	YES	NO	Explain_____
Thyroid or other endocrine problem	YES	NO	Explain_____
Use of alcohol or drugs	YES	NO	Explain_____
Any other significant problems	YES	NO	Explain_____