58115 Main Street
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Initial History Questionnaire

Form Completed By:	Date:

Name:	ID Number:	
Birth Date:	Age:	☐ Male ☐ Female

Household

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 the mother and father are not living together or 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 at term? Early? Late?

If early, how many weeks' gestation?

Did mother have any illness or problems with her pregnancy?

During the pregnancy, did mother

Smoke Yes No

Drink alcohol Yes No

Use drugs or medications Yes No

What

When

Was the delivery Vaginal Cesarian

If cesarean, why?

Did your baby have any problems right after birth? Yes No

Explain:

Was initial feeding

Did your baby go home with mother from the hospital? Yes No

Explain:

Was mother positive for Group B strep? Yes No

Was mother positive for Hepatitis B? Yes No

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 any serious injuries or accidents? ☐ Yes ☐ No

Explain:

Has your child had an surgery? ☐ Yes ☐ No

Explain:

Has your child ever been hospitalized? ☐ Yes ☐ No

Explain:

Any reactions to any immunizations? ☐ Yes ☐ No

Explain:

Is your child allergic to any medications or drugs? ☐ Yes ☐ No

Explain:

Is your child on any medications, drugs or supplements? ☐ 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

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:

Family History (continued)

Bleeding Disorder	☐	☐	Who:	Comments:
Liver disease	☐	☐	Who:	Comments:
Kidney disease	☐	☐	Who:	Comments:
Diabetes (before 50 years old)				
	☐	☐	Who:	Comments:
Bed-wetting (after 10 years old)				
	☐	☐	Who:	Comments:
Epilepsy or convulsions	☐	☐	Who:	Comments:
Alcohol abuse	☐	☐	Who:	Comments:
Drug abuse	☐	☐	Who:	Comments:
Mental illness	☐	☐	Who:	Comments:
Mental retardation	☐	☐	Who:	Comments:
Immune problems, HIV, or AIDS				
	☐	☐	Who:	Comments:
Cancer	☐	☐	Who:	Comments:
Stroke			Who:	Comments:

Additional family history

Past History

Does your child have, or has he/she ever had:

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:
Frequent abdominal pain	Explain:
Constipation requiring doctor visits	Explain:
Bladder or kidney infection	Explain:
Bed-wetting (after 5years old)	Explain:
(For girls) Has she started her menstrual periods?	Explain:
(For girls) Are there problems with her periods?	Explain:
Any chronic or recurrent skin problems (acne, eczema, etc.)	Explain:
Frequent headaches	Explain:
Convulsions or other neurologic problem	Explain:
Diabetes	Explain:
Thyroid or other endocrine problem	Explain:

Any other significant problem	Explain:
Use of alcohol or drugs	Explain: