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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 Cesarean

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:

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: