

## Initial History Questionnaire

Name \_\_\_\_\_ ID Number \_\_\_\_\_

Birth Date \_\_\_\_\_ Age \_\_\_\_\_  M  F

Form Completed By \_\_\_\_\_ Date Completed \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Whom can we thank for referring you? \_\_\_\_\_

### Illness/Injuries

Do you consider your child to be in good health?  Yes  No Explain \_\_\_\_\_

Does your child have a serious illness or medical condition?  Yes  No Explain \_\_\_\_\_

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

Any chronic or recurrent skin problem (acne, eczema, etc.)?  Yes  No Explain \_\_\_\_\_

Use of alcohol or drugs?  Yes  No Explain \_\_\_\_\_

Nasal allergies?  Yes  No Explain \_\_\_\_\_

Anemia or bleeding problem?  Yes  No Explain \_\_\_\_\_

Asthma, bronchitis, bronchiolitis or pneumonia?  Yes  No Explain \_\_\_\_\_

Bed-wetting (after 5 years old)?  Yes  No Explain \_\_\_\_\_

Bladder or kidney infection?  Yes  No Explain \_\_\_\_\_

Blood transfusion?  Yes  No Explain \_\_\_\_\_

Constipation requiring doctor visits?  Yes  No Explain \_\_\_\_\_

Convulsions or other neurologic problem?  Yes  No Explain \_\_\_\_\_

Diabetes?  Yes  No Explain \_\_\_\_\_

Frequent ear infections?  Yes  No Explain \_\_\_\_\_

Problems with ears or hearing?  Yes  No Explain \_\_\_\_\_

Problems with eyes or vision?  Yes  No Explain \_\_\_\_\_

Frequent abdominal pain?  Yes  No Explain \_\_\_\_\_

Frequent headaches?  Yes  No Explain \_\_\_\_\_

Any heart problem or heart murmur?  Yes  No Explain \_\_\_\_\_

Thyroid or other endocrine problem?  Yes  No Explain \_\_\_\_\_

Any other significant problem?  Yes  No Explain \_\_\_\_\_

Has your child had serious injuries or accidents?  Yes  No Explain \_\_\_\_\_

### Surgery/Hospitalization

Has your child had any surgery?  Yes  No Explain \_\_\_\_\_

Is your child allergic to any medicines or drugs?  Yes  No Explain \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No Explain \_\_\_\_\_

### (For girls) OB-GYN

Has she started her menstrual periods?  Yes  No Explain \_\_\_\_\_

Are there problems with her periods?  Yes  No Explain \_\_\_\_\_



## **Birth History**

Was the baby born at term?  Yes  No  Early?  Late?

If early, how many weeks gestation? \_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

If cesarean, why? \_\_\_\_\_

Birth weight \_\_\_\_\_

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 What? \_\_\_\_\_ When? \_\_\_\_\_

## **Family History**

Have any family members had the following:

Immune problems, HIV or AIDS ?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Nasal allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Anemia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Asthma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bed-wetting (after 10 years old)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Birth defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Bleeding disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Diabetes (before 50 years old)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Drug abuse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or convulsions?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Deafness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Heart disease (before 50 years old)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
High blood pressure (before 50 years old)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Kidney disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Liver disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Mental retardation?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Migraines?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Scoliosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Thyroid disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____
Additional family history?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Who _____	Comments _____



**Home Environment**

Mother's full name: \_\_\_\_\_

Mother's occupation: \_\_\_\_\_

Father's full name: \_\_\_\_\_

Father's occupation: \_\_\_\_\_

Please list all those living in the child's home.

<u>Name</u>	<u>Relationship to Child</u>	<u>Date of Birth</u>	<u>Health Problems</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

\_\_\_\_\_

If mother and father are not living together or if 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 the child see the parent/parents not in the home?

\_\_\_\_\_

Is your child exposed to smoke in the home?  Yes  No Explain \_\_\_\_\_

Are there pets in the home?  Yes  No Explain \_\_\_\_\_

**Development**

Are you concerned about your child's:

Attention span?  Yes  No Explain \_\_\_\_\_

Mental or emotional development?  Yes  No Explain \_\_\_\_\_

Physical development?  Yes  No Explain \_\_\_\_\_

If your child is in school:

How is his/her behavior in school? \_\_\_\_\_

\_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_

\_\_\_\_\_

Is he/she in special or resource classes? \_\_\_\_\_

\_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_

\_\_\_\_\_

