

Initial Pediatric History Questionnaire

Patient Name:	Birth Date:
Age:	Birth Gender: M F Gender Identity : _____
Form Completed By:	Date Completed:

Household

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

Name	Relationship to the child	Birth Date	Health Problems

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

What is the child's living situation if not with both biological parents?

Lives with adoptive parents Joint Custody Single Custody Lives with Foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not at home?

Birth History Don't know birth history

Birth weight _____. Was the baby born at term? _____

Weeks: _____

Were there any prenatal complications?

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

During pregnancy, did mother:

Use tobacco Yes No Use prenatal vitamins

What _____ When _____

Was the delivery Vaginal Cesarean If cesarean, why?

Was initial feeding Formula Breast milk

How long breastfed? _____

Did your baby go home with mother from hospital?

Yes No Explain _____

General DK= Don't know

Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have and serious illness or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to any medicine or drugs? Yes No DK Explain _____

Is your child currently taking any medication? If so, please list name, dose, and how often _____

Biological Family History DK= Don't know

Have any family members had any of the following?

Childhood hearing loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Heart Disease (before 50 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 50 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Substance (Including Tobacco) Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental Illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional Family History _____					

Past History

Does your child have, or has your child ever had,

Chicken Pox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent Ear Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem/murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visit	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bladder or kidney infection	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 yrs old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic/recurrent skin problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions/ other neurologic problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any other significant problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
For Girls:				
Has she started menstrual period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Are there problems with periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____

Development

Are you concerned about your child's physical development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you concerned about your child's mental or emotional development?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you concerned about your child's attention span?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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? _____		