Initial Pediatric History Questionnaire (Rev 2-23)

Patient Name:	Birth Date:		Age:		Date Completed:			
Preferred Name:	Birth Gender :	M	F	Gender Identity:	M	F	NB	
Form Completed By:	Romantic Interest:	M	F	Unknown				

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 MEDICATIONS? If so, please list name, dose, and how often: _____

_____

_____

Past History

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

Chicken Pox? ❒Yes ❒No ❒DK When _____
Frequent Ear Infections? ❒Yes ❒No ❒DK Explain_____
Problems with ears or hearing? ❒Yes ❒No ❒DK Explain_____
Nasal Allergies? ❒Yes ❒No ❒DK Explain_____
Problems with eyes or vision? ❒Yes ❒No ❒DK Explain _____
Asthma, bronchitis or pneumonia? ❒Yes ❒No ❒DK Explain _____
Any heart problem/murmur? ❒Yes ❒No ❒DK Explain_____
Convulsions/ other neurologic problem? ❒Yes ❒No ❒DK Explain_____
Frequent abdominal pain? ❒Yes ❒No ❒DK Explain_____
Constipation requiring doctor visit? ❒Yes ❒No ❒DK Explain_____
Bladder or kidney infection? ❒Yes ❒No ❒DK Explain_____
Bed-wetting (after 5 yrs old)? ❒Yes ❒No ❒DK Explain_____
Chronic/recurrent skin problem? ❒Yes ❒No ❒DK Explain_____
Frequent headaches? ❒Yes ❒No ❒DK Explain_____
Are there Guns in the house? ❒Yes ❒No ❒DK Explain_____
Any Depression? Suicide Attempt? Cutting? ❒Yes ❒No ❒DK Explain_____
Use of alcohol, marijuana, or other? ❒Yes ❒No ❒DK Explain_____
Is your child dating or sexually active? Which? ❒Yes ❒No ❒DK Explain_____
Does your child prefer to date boys, girls, or both? ❒Yes ❒No ❒DK Explain_____

For Girls:

Has she started menstrual period? ❒Yes ❒No ❒DK When_____
Are there problems with periods? (Irregular? Heavy?) ❒Yes ❒No ❒DK Explain_____
OTHER _____

School / Development

Are you concerned about your child's physical development? ❒Yes ❒No _____
Are you concerned about your child's mental or emotional development? ❒Yes ❒No _____
Are you concerned about your child's attention span? ❒Yes ❒No _____
Are there behavior issues in school? ❒Yes ❒No _____
Has he/she failed or repeated a grade in school? ❒Yes ❒No _____
Are there issues with academic subjects? ❒Yes ❒No _____
Is he/she in special or resource classes? ❒Yes ❒No _____

Biological Family History DK= Don't know

Have any family members had any of the following?

Childhood hearing loss ❒Yes ❒No ❒DK Who_____ Comments _____
Asthma ❒Yes ❒No ❒DK Who_____ Comments _____
Tuberculosis ❒Yes ❒No ❒DK Who_____ Comments _____
Heart Disease (before 50 yrs old) ❒Yes ❒No ❒DK Who _____ Comments _____
High Cholesterol ❒Yes ❒No ❒DK Who_____ Comments _____
Anemia ❒Yes ❒No ❒DK Who_____ Comments _____
Bleeding Disorder ❒Yes ❒No ❒DK Who_____ Comments _____
Liver Disease ❒Yes ❒No ❒DK Who_____ Comments _____
Kidney Disease ❒Yes ❒No ❒DK Who_____ Comments _____
Diabetes (before 50 yrs old) ❒Yes ❒No ❒DK Who_____ Comments _____
Bed-wetting (after 10 yrs old) ❒Yes ❒No ❒DK Who_____ Comments _____
Epilepsy or convulsions ❒Yes ❒No ❒DK Who_____ Comments _____
Drug or Alcohol Abuse ❒Yes ❒No ❒DK Who_____ Comments _____
Tobacco Use ❒Yes ❒No ❒DK Who_____ Comments _____
Mental illness ❒Yes ❒No ❒DK Who_____ Comments _____
Immune problems, HIV, AIDS ❒Yes ❒No ❒DK Who_____ Comments _____
Additional Family History _____