

# INITIAL HISTORY QUESTIONNAIRE

(Revised 7/04)

Form Completed By: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_ Date Completed: \_\_\_\_\_

**HOUSEHOLD**

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

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.
				_____
				_____
				_____
				_____
				_____

**BIRTH HISTORY**

<p>Birth Weight: _____</p> <p>Was the baby born at: <input type="checkbox"/> Term <input type="checkbox"/> Early <input type="checkbox"/> Late</p> <p>If early, how many weeks' gestation? _____</p> <p>Did mother have any illness or problem with her pregnancy?  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain: _____</p> <p>During the pregnancy, did mother:</p> <p style="padding-left: 20px;">Smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No      Drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">Use drugs or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="padding-left: 20px;">If yes, list names: _____</p>	<p>Were pre-natal ultrasounds read as "normal"??  <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Explain: _____</p> <p>Was the delivery: <input type="checkbox"/> Vaginal? <input type="checkbox"/> Cesarean?</p> <p>If Cesarean, why? _____</p> <p>Did your baby have any problems right after birth:  <input type="checkbox"/> Yes <input type="checkbox"/> No      Explain: _____</p> <p>Was initial feeding <input type="checkbox"/> Breast? <input type="checkbox"/> Bottle?</p> <p>Did your baby go home with mother from the hospital?  <input type="checkbox"/> Yes <input type="checkbox"/> No      Explain: _____</p>
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**GENERAL**

Do you consider your child to be in good health?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____
Does your child have any serious illness or medical condition?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____
Has your child had serious injuries or accidents?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____
Has your child had any surgery?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____
Has your child ever been hospitalized?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____
Is your child allergic to any medicines or drugs?	_ Yes <input type="checkbox"/> _ No <input type="checkbox"/> Explain: _____

**DEVELOPMENT**

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

**NAME:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_

**Form Reviewed By:** \_\_\_\_\_

# INITIAL HISTORY QUESTIONNAIRE

(Revised 7/04)

## FAMILY HISTORY

Have any family members had the following:

Deafness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Nasal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Heart Disease (Before 50 Years Old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
High Blood Pressure (Before 50 Years Old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Bleeding Disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Liver Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Kidney Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Diabetes (Before 50 Years Old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Bed Wetting (After 10 Years Old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Epilepsy or Convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Alcohol Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Drug Abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Mental Illness (Depression, Bipolar Disorder)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Mental Retardation	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Immune Problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Birth Defects	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who: _____	Explain: _____
Additional Family History:	_____			

## PAST HISTORY

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

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____
Frequent Ear Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Problems with Ears or Hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Nasal Allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Problems with Eyes or Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Asthma, Bronchitis, Bronchiolitis, or Pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Any Heart Problem or Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Anemia or Bleeding Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Frequent Abdominal Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Constipation Requiring Doctor Visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Bladder or Kidney Infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Bed Wetting (After 5 Years Old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
(For Girls) Has she started her menstrual periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When: _____
(For Girls) Are there problems with her periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Any chronic or recurrent skin problem (Acne, Eczema, Etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Frequent Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Convulsions or other Neurologic Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Thyroid or Other Endocrine Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Any Other Significant Problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____
Use of Alcohol or Drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain: _____

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

Form Reviewed By: \_\_\_\_\_

Provider/Annapolis Pediatrics