



INITIAL HISTORY QUESTIONNAIRE	
Patient Name	Date Completed
Form Completed By	Patient Birth Date
Male Female	Age

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 mother and father are not living together or if child does not live with parents, what is the child's current custody status?

If one or both parents are not living in the home, how often does he or she see the parent/parents not in the home?

BIRTH HISTORY	
Birth Weight Birth Length	Was the delivery? Vaginal ___ Cesarean ___
Was the baby born at term? Early? ___ Late? ___	If Cesarean why?
If early, how many weeks gestation?	Was Initial feeding breast or bottle?
Did mother have any illness or problems with her pregnancy?	Yes? ___ No? ___ Explain _____
Did your baby have any problems right after birth?	Yes? ___ No? ___ Explain _____
During pregnancy did mother do any of the following?	Smoke ___ Drink alcohol ___ Use drugs or medications ___ What ___ When ___
Did your baby go home with mother from the hospital?	If no, please explain _____

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 serious injuries or accidents?	Yes ___ No ___ Explain _____
Has your child had any surgery?	Yes ___ No ___ Explain _____
Has your child ever been hospitalized?	Yes ___ No ___ Explain _____
Is your child allergic to any medicines or drugs?	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 class?	

FAMILY HISTORY

Have any family members had any of 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	Yes	No	Who	Comments
High Blood Pressure < 50	Yes	No	Who	Comments`
High Cholesterol	Yes	No	Who	Comments
Anemia	Yes	No	Who	Comments
Bleeding Disorder	Yes	No	Who	Comments
Liver Disease	Yes	No	Who	Comments
Kidney Disease	Yes	No	Who	Comments
Diabetes < 50	Yes	No	Who	Comments
Bed Wetting > 10	Yes	No	Who	Comments
Epilepsy or Convulsions	Yes	No	Who	Comments
Alcohol Abuse	Yes	No	Who	Comments
Drug Abuse	Yes	No	Who	Comments
Mental Illness	Yes	No	Who	Comments
Mental Retardation	Yes	No	Who	Comments
Immune Problems HIV or Aids	Yes	No	Who	Comments
Additional Family History	Yes	No	Who	Comments

PAST HISTORY

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

Chickenpox	Yes	No	When
Frequent Ear Infections	Yes	No	Explain
Problems with ears or hearing	Yes	No	Explain
Nasal Allergies	Yes	No	Explain
Problems with eyes or vision	Yes	No	Explain
Asthma, bronchitis, or pneumonia	Yes	No	Explain
Any heart problem or heart murmur	Yes	No	Explain
Anemia or bleeding problem	Yes	No	Explain
Blood Transfusion	Yes	No	Explain
Frequent Abdominal pain	Yes	No	Explain
Constipation requiring doctor visits	Yes	No	Explain
Bladder or kidney infection	Yes	No	Explain
Bed wetting > 5 years old	Yes	No	Explain
(For girls) Has she started her menstrual period	Yes	No	When
(For girls) Are there problems with her periods	Yes	No	Explain
Any chronic or recurrent skin problem (acne, eczema, etc.)	Yes	No	Explain
Frequent Headaches	Yes	No	Explain
Convulsion or other neurological problem	Yes	No	Explain
Diabetes	Yes	No	Explain
Thyroid or other endocrine problem	Yes	No	Explain
Any other significant problem	Yes	No	Explain
Use of alcohol or drugs	Yes	No	Explain