

Initial History Questionnaire- New Patient

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

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 name and age and where they live. _____

If mother & 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 he/she see the parent/parents not in home? _____

Mother's Occupation _____

Mother's Employer _____

Father's Occupation _____

Father's Employer _____

Does anyone in the home use tobacco? Yes No

Are there any pets in the home? Yes No

BIRTH HISTORY

Birth Weight _____

Was delivery Vaginal Cesarean?

Was the baby born at term? Yes No Early Late

If Cesarean, why? _____

If early, how many week's gestation? _____

Did mother have any illness/problems with pregnancy?

Did your baby have any issues right after birth?

Yes No Explain _____

Yes No Explain _____

During pregnancy, did mother

Was initial feeding Breast Bottle

Smoke? Yes No Drink alcohol? Yes No

Did the baby go home with mother from hospital?

Use drugs or medications Yes No

Yes No Explain: _____

What _____ When _____

GENERAL

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 _____

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

Has your child had surgery of any kind? 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 emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

Is your child in school? Yes No Explain _____

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 resource classes? _____

Please proceed to back of page

FAMILY HISTORY

Has any family member had the following:

Deafness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Nasal allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Asthma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Tuberculosis?	<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 blood pressure (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 _____
Anemia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Bleeding disorder?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Liver disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Kidney disease?	<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 _____
Bed-wetting (after 10 years old)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Epilepsy or convulsions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Alcohol abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Drug Abuse?	<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 _____
Immune problems, HIV or AIDS?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
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	When _____
Problems with ears or hearing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Nasal allergies?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Problems with eyes or vision?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Asthma, bronchitis, bronchiolitis or pneumonia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Any heart problems or murmur?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Anemia or bleeding problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Blood transfusion?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent abdominal pain?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Constipation requiring doctor visit?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Bladder or kidney infection?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Bed wetting (after 5 years old)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
(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	When _____
Any chronic or recurrent skin problems? (Acne, Eczema, etc)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Frequent headaches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Convulsions or other neurological problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Thyroid or other endocrine problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Any other significant problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____
Use of alcohol and abuse?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	When _____