Patient - Initial History Questionnaire				
Name (Last, First, MI)		ID NUMBER		
Form Completed by	Date Completed	DOB	AGE	M/F

Please Name all those living in the child's home	Relationship to child	DOB	Health Problems

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

_____

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

_____

Maternal and Birth History			
Maternal Age at time of Delivery:	Health Status:		
Prenatal Testing Results: Hepatitis B___ GBS ___Chlamydia___ Gonorrhea___ Syphilis___ HIV___	Chromosomal tests:	Abnormal Ultrasound results:	
Birth weight / Length / Head	Was delivery vaginal Yes/No	If cesarean, why?	
Born at how many weeks gestation?	Did the baby have any problems at birth? Yes/No	Please explain	
Was the initial feeding Breast/Bottle	Did your baby go home with mother from the hospital? Yes/No	Did mother have any illness or problems with her pregnancy? Yes/No	
During pregnancy, did mother smoke, drink alcohol, use drugs, medications, or have any infections? Yes/No		What?	When?
Hearing test passed at birth? Yes/No		Hepatitis B vac given? Yes/No	Vitamin K given? Yes/No

<u>Child's General Health History</u>:

Do you consider your child to be in good health? Yes/No Explain_____

Does your child have any serious illness or condition? Yes/No Explain_____

Has your child had any serious injuries or accidents? Yes/No Explain_____

Has your child had any surgeries or accidents? Yes/No Explain_____

Has your child ever been hospitalized? Yes/No Explain_____

Is your child allergic to foods, medicines or insects? Yes/No Explain_____

Child's Developmental History:

Are you concerned about your child's physical development? Yes/No Explain_____

Are concerned about your child's mental development? Yes/No Explain_____

Are you concerned about your child's attention span? Yes/No Explain_____

If your child is enrolled in a school:

How is his 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?_____

Additional History:

Please circle and elaborate if anyone in your child has had:

Chickenpox, Frequent ear infections, Hearing problems, Vision problems, Asthma, Bronchitis, Wheezing, Pneumonia, Heart Problems, Heart Murmurs, Anemia, Blood Transfusions, Frequent Abdominal Pain, Constipation, Kidney/Bladder Infection, Bedwetting (over age 10), Skin problems, Frequent Headaches, Convulsions, Diabetes, Thyroid Problems, Alcohol or Substance Abuse.

_____

_____

_____

(For girls) Has your daughter started her menstrual periods? _____

(For girls) Are there problems with her periods? _____

Family History:

Please circle and elaborate if anyone in your family has had:

Deafness, Nasal Allergies, Asthma, Tuberculosis, Heart Disease (before age 50), High Blood Pressure (before age 50), High Cholesterol, Anemia, Bleeding Disorders, Liver Disease, Kidney Disease, Diabetes (before age 50), Bed Wetting (beyond age 10), Epilepsy or convulsions, Alcohol or Substance Abuse, Mental Illness, Developmental Delay, Immunity Problems (i.e. HIV or AIDS),

Additional family health history:

_____

_____

_____

_____

_____

Hospitalizations, Surgeries and Serious Accidents:

What happened?	Hospital	Date	Result

Evaluations:

Type of Specialist	Reason	Date	Result