

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M \_\_\_\_\_ F \_\_\_\_\_

## 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. \_\_\_\_\_

If mother and 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 the home? \_\_\_\_\_

## Birth History

Birth weight \_\_\_\_\_

Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If early, how many weeks' gestation? \_\_\_\_\_

Did mother have any illness or problem with her pregnancy?

Yes  No Explain \_\_\_\_\_

During pregnancy, did mother

Smoke  Yes  No

Drink alcohol  Yes  No

Use drugs or medications  Yes  No

What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

If cesarean, why? \_\_\_\_\_

Did your baby have any problems right after birth?

Yes  No Explain \_\_\_\_\_

Was initial feeding  Breast?  Bottle?

Did your baby go home with mother from the hospital?

Yes  No 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 classes? \_\_\_\_\_



## Family History

Have any family members 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 | 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 infection                               | <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 problem                   | <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 _____ |