danville pediatrics

Initial History Questionnaire

Name_____
Birth Date_____
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 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 the child see the parent/parents not in the home?_____
_____.

Birth History:

Birth Weight:_____ Was the delivery Vaginal☐ Cesarean ☐
Was baby born at term?____ Early?____ Late?____ If cesarean, why?_____
If early, how many weeks gestation?_____ Did your baby have any problems right after birth? Yes☐ No☐
Explain:_____
Did mother have any illness or problem with pregnancy? Yes☐ No☐ Explain if yes_____
_____.
During pregnancy, did mother: Smoke: Yes☐ No☐ Drink alcohol: Yes☐ No☐
Use drugs/medications: Yes☐ No☐ What?_____ When?_____
Was baby's 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/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 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: **Name**:_____

Have any family members had the following:

Deafness	Yes☐	No☐	Who?_____	Comment_____
Nasal Allergies	Yes☐	No☐	Who?_____	Comment_____
Asthma	Yes☐	No☐	Who?_____	Comment_____
Tuberculosis	Yes☐	No☐	Who?_____	Comment_____
Heart Disease (before 50)	Yes☐	No☐	Who?_____	Comment_____
High Blood Pressure	Yes☐	No☐	Who?_____	Comment_____
High Cholesterol	Yes☐	No☐	Who?_____	Comment_____
Anemia	Yes☐	No☐	Who?_____	Comment_____
Bleeding Disorder	Yes☐	No☐	Who?_____	Comment_____
Liver Disease	Yes☐	No☐	Who?_____	Comment_____
Kidney Disease	Yes☐	No☐	Who?_____	Comment_____
Diabetes (before 50)	Yes☐	No☐	Who?_____	Comment_____
Bed-wetting (after 10)	Yes☐	No☐	Who?_____	Comment_____
Epilepsy or convulsions	Yes☐	No☐	Who?_____	Comment_____
Alcohol abuse	Yes☐	No☐	Who?_____	Comment_____
Drug abuse	Yes☐	No☐	Who?_____	Comment_____
Mental Illness	Yes☐	No☐	Who?_____	Comment_____
Mental retardation	Yes☐	No☐	Who?_____	Comment_____
Immune problems,HIV/Aids	Yes☐	No☐	Who?_____	Comment_____

Additional Family History:_____
_____.
_____.
_____.
_____.
_____.

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, bronchiolitis, 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 (after 5 years old)	Yes☐	No☐	Explain_____	
For girls, has she started her menstrual periods	Yes☐	No☐	Explain_____	
For girls, any problems with her periods	Yes☐	No☐	Explain_____	
Any chronic or recurrent skin problem (acne,eczema,etc)	Yes☐	No☐	Explain_____	
Frequent headaches	Yes☐	No☐	Explain_____	
Convulsions 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_____	