Initial History Questionnaire

Name_____ **ID Number**_____

Birth Date_____ **Age**_____ ❑ **M** ❑ **F**

Form Completed By_____ **Date Completed** _____

How did you hear about us?_____

Whom can we thank for referring you?_____

Illness/Injuries

Do you consider your child to be in good health?	❑Yes	❑ No	Explain_____
Does you child have a serious illness or medical condition?	❑Yes	❑ No	Explain_____
Does your child have, or has he/she ever had:			
Any chronic or recurrent skin problem (acne, eczema, etc.)?	❑Yes	❑ No	Explain_____
Use of alcohol or drugs?	❑Yes	❑ No	Explain_____
Nasal allergies?	❑Yes	❑ No	Explain_____
Anemia or bleeding problem?	❑Yes	❑ No	Explain_____
Asthma, bronchitis, bronchiolitis or pneumonia?	❑Yes	❑ No	Explain_____
Bed-wetting (after 5 years old)?	❑Yes	❑ No	Explain_____
Bladder or kidney infection?	❑Yes	❑ No	Explain_____
Blood transfusion?	❑Yes	❑ No	Explain_____
Constipation requiring doctor visits?	❑Yes	❑ No	Explain_____
Convulsions or other neurologic problem?	❑Yes	❑ No	Explain_____
Diabetes?	❑Yes	❑ No	Explain_____
Frequent ear infections?	❑Yes	❑ No	Explain_____
Prob!ems with ears or hearing?	❑Yes	❑ No	Explain_____
Problems with eyes or vision?	❑Yes	❑ No	Explain_____
Frequent abdominal pain?	❑Yes	❑ No	Explain_____
Frequent headaches?	❑Yes	❑ No	Explain_____
Any heart problem or heart murmur?	❑Yes	❑ No	Explain_____
Thyroid or other endocrine problem?	❑Yes	❑ No	Explain_____
Any other significant problem?	❑Yes	❑ No	Explain_____
Has your child had serious injuries or accidents?	❑Yes	❑ No	Explain_____

Surgery/Hospitalization

Has your child had any surgery?	❑Yes	❑ No	Explain_____
Is your child allergic to any medicines or drugs?	❑Yes	❑ No	Explain_____
Has your child ever been hospitalized?	❑Yes	❑ No	Explain_____

(For girls) OB-GYN

Has she started her menstrual periods?	❑Yes	❑ No	Explain_____
Are there problems with her periods?	❑Yes	❑ No	Explain_____

Birth History

Was the baby born at term? ❑ Yes ❑ No ❑ Early? ❑ Late?

If early, how many weeks gestation?_____

Was the delivery ❑ Vaginal? ❑ Cesarean?

If cesarean, why?_____

Birth weight_____

Did rnother 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?_____

Family History

Have any family members had the following:

Immune problems, HIV or AIDS ?	❑ Yes	❑ No	Who _____	Comments_____
Alcohol abuse?	❑ Yes	❑ No	Who _____	Comments_____
Nasal allergies?	❑ Yes	❑ No	Who _____	Comments_____
Anemia?	❑ Yes	❑ No	Who _____	Comments_____
Asthma?	❑ Yes	❑ No	Who _____	Comments_____
Bed-wetting (after 10 years old)?	❑ Yes	❑ No	Who _____	Comments_____
Birth defects?	❑ Yes	❑ No	Who _____	Comments_____
Bleeding disorder?	❑ Yes	❑ No	Who _____	Comments_____
Cancer?	❑ Yes	❑ No	Who _____	Comments_____
Diabetes (before 50 years old)?	❑ Yes	❑ No	Who _____	Comments_____
Drug abuse?	❑ Yes	❑ No	Who _____	Comments_____
Epilepsy or convulsions?	❑ Yes	❑ No	Who _____	Comments_____
Deafness?	❑ Yes	❑ No	Who _____	Comments_____
Heart disease (before 50 years old)?	❑ Yes	❑ No	Who _____	Comments_____
High cholesterol?	❑ Yes	❑ No	Who _____	Comments_____
High blood pressure (before 50 years old)?	❑ Yes	❑ No	Who _____	Comments_____
Kidney disease?	❑ Yes	❑ No	Who _____	Comments_____
Liver disease?	❑ Yes	❑ No	Who _____	Comments_____
Mental illness?	❑ Yes	❑ No	Who _____	Comments_____
Mental retardation?	❑ Yes	❑ No	Who _____	Comments_____
Migraines?	❑ Yes	❑ No	Who _____	Comments_____
Scoliosis?	❑ Yes	❑ No	Who _____	Comments_____
Thyroid disorder?	❑ Yes	❑ No	Who _____	Comments_____
Tuberculosis?	❑ Yes	❑ No	Who _____	Comments_____
Additional family history?	❑ Yes	❑ No	Who _____	Comments_____

Home Environment

Mother's full name: _____

Mother's occupation: _____

Father's full name: _____

Father's occupation: _____

Please list all those living in the child's home.

Name	Relationship to Child	Date of Birth	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?

_____

_____

Is your child exposed to smoke in the home? ❑Yes ❑ No Explain _____

Are there pets in the home? ❑Yes ❑ No Explain _____

Development

Are you concerned about your child's:

Attention span? ❑Yes ❑ No Explain _____

Mental or emotional development? ❑Yes ❑ No Explain _____

Physical development? ❑Yes ❑ No Explain _____

If you child is in school:

How is his/her behavior in school? _____

_____

How is he/she doing in academic subjects? _____

_____

Is he/she in special or resource classes? _____

_____

Has he/she failed or repeated a grade in school? _____

_____