

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 medicine 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	___ Yes ___ No	Who _____	Comments _____
Nasal allergies	___ Yes ___ No	Who _____	Comments _____
Asthma	___ Yes ___ No	Who _____	Comments _____
Tuberculosis	___ Yes ___ No	Who _____	Comments _____
Heart disease (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
High blood pressure (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
High cholesterol	___ Yes ___ No	Who _____	Comments _____
Anemia	___ Yes ___ No	Who _____	Comments _____
Bleeding disorder	___ Yes ___ No	Who _____	Comments _____
Liver disease	___ Yes ___ No	Who _____	Comments _____
Kidney disease	___ Yes ___ No	Who _____	Comments _____
Diabetes (before 50 years old)	___ Yes ___ No	Who _____	Comments _____
Bed-wetting (after 10 years old)	___ Yes ___ No	Who _____	Comments _____
Epilepsy or convulsions	___ Yes ___ No	Who _____	Comments _____
Alcohol abuse	___ Yes ___ No	Who _____	Comments _____
Drug abuse	___ Yes ___ No	Who _____	Comments _____
Mental illness	___ Yes ___ No	Who _____	Comments _____
Mental retardation	___ Yes ___ No	Who _____	Comments _____
Immune problems, HIV, or AIDS	___ Yes ___ No	Who _____	Comments _____

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	When _____
(For girls) Are there problems with her periods?	___ Yes ___ No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	___ Yes ___ No	Explain _____
Frequent headaches	___ Yes ___ No	Explain _____
Convulsions or other neurologic problems	___ 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 _____