



## Initial History Questionnaire

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_

Form completed by: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

Name	Relationship	Birth date	Health problems

Are there siblings not listed? If so please list their names, ages, and where they live: \_\_\_\_\_

Does the child live with:  Biological parents  Adoptive parents  Foster family  Joint custody  
 Single custody?

**Birth History:**

Birth weight: \_\_\_\_\_ was the child born term or preterm? \_\_\_\_\_

# weeks at birth? \_\_\_\_\_ were there any prenatal or neonatal complications?  Yes

No. If yes, explain: \_\_\_\_\_

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Was the birth  Vaginal  Cesarean? If Cesarean, why? \_\_\_\_\_

Did the baby have to stay in the hospital for any reason?  Yes  No

If yes, explain: \_\_\_\_\_

During pregnancy did mother: use tobacco:  Yes  No, drink alcohol:  Yes  No,  
use illegal drugs:  Yes  No, use medications:  Yes  No, use prenatal vitamins:  Yes  No,

if yes to any of the above explain: \_\_\_\_\_

**General:**

Do you consider your child to be in good health?  Yes  No, Explain: \_\_\_\_\_

Does your child have any serious illnesses or medical conditions?  Yes  No Explain: \_\_\_\_\_

Has your child had any surgeries?  Yes  No Explain: \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No Explain: \_\_\_\_\_

Is your child taking any medications?  Yes  No; Please list: \_\_\_\_\_

Is your child allergic to any medications?  Yes  No Explain: \_\_\_\_\_

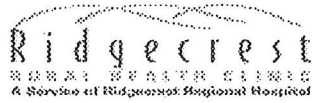
**Biological Family History**

(M= mother, F= father, S= siblings, MGP= maternal grandparents, PGP= paternal grandparents)

**Have any family members had the following?**

	M	F	S	MGP	PGP
1. Childhood hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Heart disease (before 55 years old)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<b>M</b>	<b>F</b>	<b>S</b>	<b>MGP</b>	<b>PGP</b>
5. Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Liver disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Epilepsy or convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Alcohol/drug abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Diabetes/thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Mental illness/depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Developmental disability	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Past History: Does your child have or has your child ever had?**

<b>Yes</b>	<b>No</b>	
<input type="checkbox"/>	<input type="checkbox"/>	1. Problems with ears or hearing
<input type="checkbox"/>	<input type="checkbox"/>	2. Nasal allergies
<input type="checkbox"/>	<input type="checkbox"/>	3. Asthma, bronchitis, bronchiolitis, or pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	4. Any heart problem or heart murmur
<input type="checkbox"/>	<input type="checkbox"/>	5. Anemia or bleeding problems
<input type="checkbox"/>	<input type="checkbox"/>	6. Metabolic/genetic disorders
<input type="checkbox"/>	<input type="checkbox"/>	7. Cancer
<input type="checkbox"/>	<input type="checkbox"/>	8. Kidney disease or urologic malformations
<input type="checkbox"/>	<input type="checkbox"/>	9. Sleep problems/snoring
<input type="checkbox"/>	<input type="checkbox"/>	10. Chronic or recurrent skin problems (acne/eczema)
<input type="checkbox"/>	<input type="checkbox"/>	11. Convulsions or other neurologic problems
<input type="checkbox"/>	<input type="checkbox"/>	12. Thyroid or other endocrine problems
<input type="checkbox"/>	<input type="checkbox"/>	13. History of serious injuries/fractures/concussions
<input type="checkbox"/>	<input type="checkbox"/>	14. Developmental delay
<input type="checkbox"/>	<input type="checkbox"/>	15. History of family violence
<input type="checkbox"/>	<input type="checkbox"/>	16. (For girls) Problems with her period
<input type="checkbox"/>	<input type="checkbox"/>	17. Has had her first period

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- | Yes                      | No                       |   |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | 18. Attention deficit hyperactivity disorder/anxiety, mood problems, depression |
| <input type="checkbox"/> | <input type="checkbox"/> | 19. Any other significant problems  |

Any "yes" answers, please explain:

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