

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 delivery Vaginal? Cesarean?

Was the baby born at term? _____ Early? _____ Late? _____

If cesarean, why? _____

If early, how many weeks' gestation? _____

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?
 Yes No Explain _____

Yes No Explain _____

During pregnancy, did mother
 Smoke Yes No Drink alcohol Yes No
 Use drugs or medications Yes No
 What _____ When _____

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? _____



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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 _____