Initial History Questionnaire- New Patient

Patient Name:	Birth Date:
Age:	Gender: M F
Form Completed By:	Date:

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 name and age and where they live._____
_____

If mother & 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 home? _____
_____

Mother's Occupation_____ Mother's Employer_____
Father's Occupation _____ Father's Employer_____
Does anyone in the home use tobacco? ☐ Yes ☐ No Are there any pets in the home? ☐ Yes ☐ No

BIRTH HISTORY

Birth Weight_____ Was delivery ☐Vaginal ☐ Cesarean?
Was the baby born at term? ☐ Yes ☐ No ☐Early ☐ Late If Cesarean, why? _____
If early, how many week's gestation?_____
Did mother have any illness/problems with pregnancy? Did your baby have any issues right after birth?
☐ Yes ☐ No Explain_____ ☐ Yes ☐ No Explain _____
_____ _____
During pregnancy, did mother Was initial feeding ☐Breast ☐Bottle
Smoke? ☐Yes ☐No Drink alcohol? ☐ Yes ☐No Did the baby go home with mother from hospital?
Use drugs or medications ☐ Yes ☐ No ☐ Yes ☐ No Explain: _____
What _____ When _____

GENERAL

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain_____
Does your child have a serious illness or medical condition?	☐ Yes	☐ No	Explain_____
Has your child had serious injuries or accidents?	☐ Yes	☐ No	Explain_____
Has your child had surgery of any kind?	☐ 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 emotional development?	☐ Yes	☐ No	Explain_____
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain_____
Is your child in school?	☐ Yes	☐ No	Explain_____

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 resource classes?_____

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FAMILY HISTORY

Has any family member 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 _____
Intellectual disability?	☐ 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	When _____
Problems with ears or hearing?	☐ Yes	☐ No	When _____
Nasal allergies?	☐ Yes	☐ No	When _____
Problems with eyes or vision?	☐ Yes	☐ No	When _____
Asthma, bronchitis, bronchiolitis or pneumonia?	☐ Yes	☐ No	When _____
Any heart problems or murmur?	☐ Yes	☐ No	When _____
Anemia or bleeding problems?	☐ Yes	☐ No	When _____
Blood transfusion?	☐ Yes	☐ No	When _____
Frequent abdominal pain?	☐ Yes	☐ No	When _____
Constipation requiring doctor visit?	☐ Yes	☐ No	When _____
Bladder or kidney infection?	☐ Yes	☐ No	When _____
Bed wetting (after 5 years old)?	☐ Yes	☐ No	When _____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	When _____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	When _____
Any chronic or recurrent skin problems? (Acne, Eczema, etc)	☐ Yes	☐ No	When _____
Frequent headaches?	☐ Yes	☐ No	When _____
Convulsions or other neurological problem?	☐ Yes	☐ No	When _____
Diabetes?	☐ Yes	☐ No	When _____
Thyroid or other endocrine problem?	☐ Yes	☐ No	When _____
Any other significant problem?	☐ Yes	☐ No	When _____
Use of alcohol and abuse?	☐ Yes	☐ No	When _____