Initial History Questionnaire

Child's Full Legal Name: _____

Birth Date: _____ **Today's Date:** _____

Household- ***Please list ALL those living in the child's home.***

Name	Relationship to child	Age	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there siblings not listed? Is 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

_____

Birth History – ***If you answer YES to any of the following questions please describe:***

1.) Did your child have any health issues after birth? ***Yes No*** _____

2.) Was your child premature at birth ? ***Yes No***

General History- ***If you answer YES to any of the following questions please describe:***

1.) Do you consider your child to be in good health? ***Yes No*** _____

2.)Does your child have any serious illness or medical conditions? ***Yes No*** _____

_____

3.)Has your child had any serious injuries or accidents? ***Yes No*** _____

4.)Has your child had any surgeries? ***Yes No*** _____

5.)Has your child ever been hospitalized? ***Yes No*** _____

6.)Is your child allergic to any medications or Food? ***Yes No*** _____

7.) Is your child taking any medications/Vitamins? ***Yes No*** _____

Emotional Problems

1.)Does your child have any difficulty playing or making friends? ***Yes No***

2.)Does your child have trouble sleeping or have nightmares? ***Yes No***

Child's Name:_____

Birth Date:_____

Development- ***If you answer YES to any of the following questions please describe:***

1.) Are you concerned about your child's physical development? ***Yes No*** _____

2.) Are you concerned about your child's mental or emotional development? ***Yes No*** _____

3.) Are you concerned about your child's speech? ***Yes No*** _____

4.) Are you concerned about your child's attention span? ***Yes No*** _____

If your child is in school:

1.)Are you concerned about your child's behavior at school? ***Yes No*** _____

2.)Has your child failed or repeated a grade in school? ***Yes No*** _____

3.)How is your child in academic subjects? _____

4.)Is your child in any special or resource classes? ***Yes No*** _____

Family History

Please circle any of the following conditions that the baby's **blood** relatives have or have had. Identify relative having condition including parents, grandparents, aunt, uncle, brother or sister.

Asthma/Allergies _____ Fertility Issues _____

Strokes/Epilepsy _____ Tuberculosis/HIV _____

Thyroid Problems _____ Diabetes _____

Kidney Problems _____ Deafness _____

High Blood Pressure _____ Heart Disease _____

Bleeding Disorders _____ High Cholesterol _____

Anemia _____ Liver Disease _____

Alcohol or Drub Abuse _____ Mental Illness _____

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

Problems with ears/hearing ***Yes No*** _____ Nasal allergies ***Yes No*** _____

Problems with eyes/vision ***Yes No*** _____ Frequent headaches ***Yes No*** _____

Anemia or bleeding problems ***Yes No*** _____ Diabetes ***Yes No*** _____

Bladder or kidney infections ***Yes No*** _____ Bed-wetting (after age 5) ***Yes No*** _____

Asthma,Bronchitis,Bronchiolitis/ Pneumonia ***Yes No*** _____ Thyroid/Endocrine problems ***Yes No*** _____

Any heart problems or heart murmur ***Yes No*** _____

Child's Name:_____

Birth Date:_____

Frequent abdominal pain ***Yes No*** _____ Constipation requiring Doctor visits ***Yes No*** _____

(For Girls) Has she started her menstrual Period ***Yes No*** If Yes, any problems with her period?_____

Any chronic or recurrent skin problems (acne,eczema,etc.)_____

Convulsions or other neurologic problems ***Yes No*** _____

Use of alcohol or drugs ***Yes No*** _____ Any other significant problems ***Yes No*** _____

German Measles (Rubella)	***Yes No***	Red Measles	***Yes No***
Scarlet Fever	***Yes No***	Mumps	***Yes No***
Meningitis	***Yes No***	Chickenpox	***Yes No***