

Initial History Questionnaire

Georgetown Pediatrics, PSC

Name: _____ DOB: _____ Age: _____

Form Completed By: _____ Date Completed: _____

HOUSEHOLD Please list all people living in the child's home:

Name	Relationship to Child	DOB	Health Problems

Are there any siblings not listed? Yes No

If so, please list their names, 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(s) not in the home? _____

BIRTH HISTORY

Birth Weight: _____ Was the baby born At term? Early? Late? If early, how many weeks gestation? _____

Was the delivery Vaginal? Cesarean? If cesarean, why? _____

Did your baby have any problems right after birth? Yes No Explain _____

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 initial feeding Breast? Bottle?

Did baby go home with mom from 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/emotional development? Yes No Explain _____

Are you concerned about your child's attention span? Yes No Explain _____

Does he/she have any specific communication needs (hearing or vision issues)?

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Migraine	<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 _____
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 _____
ASD (Autism Spectrum Disorder)	<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 _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Ulcerative colitis/Crohns	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Genetic illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Who _____	Comments _____
Sudden unexplained death in person <50	<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	Explain _____
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 _____
Has she started her menstrual periods?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Explain _____
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 _____