# 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 baby born at term? _____ Early? _____ Late? _____

If early, how many weeks' gestation? _____

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 the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why? _____

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

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? _____

## Family History

Have any family members 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 _____ |
| Mental retardation | ☐ 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 | Explain _____ |
| Problems with ears or hearing | ☐ Yes | ☐ No | Explain _____ |
| Nasal allergies | ☐ Yes | ☐ No | Explain _____ |
| Problems with eyes or vision | ☐ Yes | ☐ No | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | ☐ Yes | ☐ No | Explain _____ |
| Any heart problem or heart murmur | ☐ Yes | ☐ No | Explain _____ |
| Anemia or bleeding problem | ☐ Yes | ☐ No | Explain _____ |
| Blood transfusion | ☐ Yes | ☐ No | Explain _____ |
| Frequent abdominal pain | ☐ Yes | ☐ No | Explain _____ |
| Constipation requiring doctor visits | ☐ Yes | ☐ No | Explain _____ |
| Bladder or kidney infection | ☐ Yes | ☐ No | Explain _____ |
| Bed-wetting (after 5 years old) | ☐ Yes | ☐ No | Explain _____ |
| (For girls) Has she started her menstrual periods? | ☐ Yes | ☐ No | When _____ |
| (For girls) Are there problems with her periods? | ☐ Yes | ☐ No | Explain _____ |
| Any chronic or recurrent skin problem (acne, eczema, etc) | ☐ Yes | ☐ No | Explain _____ |
| Frequent headaches | ☐ Yes | ☐ No | Explain _____ |
| Convulsions or other neurologic problem | ☐ Yes | ☐ No | Explain _____ |
| Diabetes | ☐ Yes | ☐ No | Explain _____ |
| Thyroid or other endocrine problem | ☐ Yes | ☐ No | Explain _____ |
| Any other significant problem | ☐ Yes | ☐ No | Explain _____ |
| Use of alcohol or drugs | ☐ Yes | ☐ No | Explain _____ |



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