Greater Elgin Family Care Center

Initial History Questionnaire	Patient Name		
	Medical Record 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?
□ Yes □ No Explain _____

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

_____ Was initial feeding □ Breast? □ Bottle?

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

Did your baby go home with mother 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, foods, etc.? □ Yes □ No Explain _____

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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? _____

Past History

Does your child have, or has he/she ever had:

Chicken pox? □ Yes □ No Explain _____

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, bronchiolits, 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 5yrs old) □ Yes □ No Explain _____

(For girls) Has she started her menstrual periods? □ Yes □ No Explain _____

(For girls) Are there problems with her periods? □ Yes □ No Explain _____

Any chronic or recurrent skin problems? (acne, eczema, etc.) □ Yes □ No Explain _____

Frequent headaches? □ Yes □ No Explain _____

Convulsions or other neurological problems? □ 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 tobacco or drugs? □ Yes □ No Explain _____

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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 yrs old)	□ Yes	□ No	Who _____	Comments _____
High blood pressure? (before 50 yrs old)	□ 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 yrs old)	□ Yes	□ No	Who _____	Comments _____
Bed-wetting? (after 10 yrs old)	□ Yes	□ No	Who _____	Comments _____
Epilepsy or convulsion?	□ 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 problem, HIV or AIDS?	□ Yes	□ No	Who _____	Comments _____

Additional family history _____

_____

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