

Rev. 5.2021

Household  Please list all those living in the child's home.  Name Relationship to child Birth Date health to child be in good health?  Birth History  Birth History  Birth History  Birth weight Was the baby born at term? Early? Late? If cesarean, why?  If one or both parents are not living together or if child does a 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 Waginal? Cesarean?  If cesarean, why?  Did your baby have any problems right after birth?  Yes No Explain  Was initial feeding Breast? Bottle?  During pregnancy, did mother  Smoke Yes No Drink alcohol Yes No Did your baby go home with mother from hospital?  Was initial feeding Breast? Bottle?  During pregnancy, did mother  Smoke Yes No Explain  Was initial feeding Breast? Bottle?  Dou's your child to be in good health? Pes No Explain  Does your child thave any serious illness or medical condition? Yes No Explain  Has your child had any surgery? Yes No Explain	Initial History Questionnaire				Patient Name						
Please list all those living in the child's home.    Name					Medical Record Number						
Please list all those living in the child's home.  Name Relationship to child Birth Date problems   Realth Problems   Relationship to child   Realth Problems   Relationship to child does in the child's custody status?   Realth Problems   Re				npleted	Birth Date		Age	M	F		
Are there siblings not listed? If so, please list their names an ages and where they live.  If mother and father are not living together or if child does relive 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	Household										
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Did your baby have any problems right after birth?   Yes   No   Explain     No   Explain   No   Explain   No   No   Explain   No   Expl	Birth History  Birth weight				_ Was the delivery	□ Vagina	l? □ Ces	arean?			
Yes   No   Explain	Was the baby bo	orn at term?	Early?	Late?	_ If cesarean, why?						
Did mother have any illness or problem with her pregnancy?    Yes   No   Explain	If early, how man	ny weeks gestation	n?				_				
During pregnancy, did mother  Smoke   Yes   No   Drink alcohol   Yes   No   Yes   No   Explain    Swed rugs or medications   Yes   No   When?    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    Syour child allergic to any medicines, foods, etc.?   Yes   No   Explain    For Staff use only:		•	•		· 						
Smoke   Yes   No   Drink alcohol   Yes   No   Yes   No   Explain   Use drugs or medications   Yes   No   When?    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   Is your child allergic to any medicines, foods, etc.?   Yes   No   Explain   Is your child allergic to any medicines, foods, etc.?   Yes   No   Explain    For Staff use only:					Was initial feeding	g □ Breast?	□ Bottle?				
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Has your child had serious injuries or accidents?  Has your child had any surgery?  Has your child ever been hospitalized?  S your child allergic to any medicines, foods, etc.?  How the serious injuries or accidents?  How the serious injuries or	,										
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Has your child ever been hospitalized?  s your child allergic to any medicines, foods, etc.?  For Staff use only:	•										
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For Staff use only:	Has your child ever been hospitalized?				□ Yes □ No	Explain					
•	Is your child allergic to any medicines, foods, etc.?				□ Yes □ No	Explain					
Delicat Name		•									

Development							
Are you concerned about your child's physical development?			Yes	□ No	Explain		
Are you concerned about your child's mental or emotional development?				□ 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?	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 Ex	κplain _				
Frequent ear infections?	□ Yes □ N	lo Ex	φlain _				
Problems with ears or hearing?	□ Yes □	No Ex	cplain _				
Nasal allergies?	□ Yes □						
Problems with eyes or vision?	□ Yes □	No Ex	φlain _				
Asthma, bronchitis, bronchiolits, or pneumonia?	□ Yes □	No Ex	κplain _				
Any heart problem or heart murmur?	□ Yes □	No Ex	cplain _				
Anemia or bleeding problem?	□ Yes □	No Ex	cplain _				
Blood transfusion?	□ Yes □	No Ex	cplain _				
Frequent abdominal pain?	□ Yes □	No Ex	cplain _				
Constipation requiring doctor visits?	□ Yes □	No Ex	cplain _				
Bladder or kidney infection?	□ Yes □	No Ex	cplain _				
Bed-wetting (after 5yrs old)	□ Yes □	No Ex	cplain _				
(For girls) Has she started her menstrual periods?	□ Yes □	No Ex	cplain _				
(For girls) Are there problems with her periods?	□ Yes □	No Ex	cplain _				
Any chronic or recurrent skin problems? (acne, eczema, etc.)	□ Yes □	No Ex	cplain _				
Frequent headaches?	□ Yes □	No Ex	cplain _				
Convulsions or other neurological problems?	□ Yes □	No Ex	cplain _				
Diabetes?	□ Yes □	No Ex	cplain _				
Thyroid or other endocrine problem?	□ Yes □	No Ex	cplain _				
Any other significant problem?	□ Yes □	No Ex	cplain _				
Use of alcohol tobacco or drugs?	□ Yes □	No Ex	cplain _				
For Staff use only: Patient Name: Rev. 5.2021	DOB:				MRN:		

Family History			
Have any family members had the following:			
Deafness?	□ Yes	□ No	WhoComments
Nasal allergies?	□ Yes	□ No	WhoComments
Asthma?	□ Yes	□ No	WhoComments
Tuberculosis?	□ Yes	□ No	WhoComments
Heart disease? (before 50 yrs old)	□ Yes	□ No	WhoComments
High blood pressure? (before 50 yrs old)	□ Yes	□ No	WhoComments
Anemia?	□ Yes	□ No	WhoComments
Bleeding disorder?	□ Yes	□ No	WhoComments
Liver disease?	□ Yes	□ No	WhoComments
Kidney disease?	□ Yes	□ No	WhoComments
Diabetes? (before 50 yrs old)	□ Yes	□ No	WhoComments
Bed-wetting? (after 10 yrs old)	□ Yes	□ No	WhoComments
Epilepsy or convulsion?	□ Yes	□ No	WhoComments
Alcohol abuse?	□ Yes	□ No	WhoComments
Drug abuse?	□ Yes	□ No	WhoComments
Mental illness?	□ Yes	□ No	WhoComments
Mental retardation?	□ Yes	□ No	WhoComments
Immune problem, HIV or AIDS?	□ Yes	□ No	WhoComments
Additional family history			

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