INITIAL HISTORY QUESTIONNAIRE

_____
Name

_____
ID Number

_____ _____
Form completed by Date completed

_____/_____
Birth Date Age

HOUSEHOLD

Please list all those living in the child's home.

Name	Relationship to child	Birth date	Health problems

Are there any siblings not listed? If no, 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(s) not living 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 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 any 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 _____

If your child is in school:

How is her/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 age 50)	☐ Yes	☐ No	Who _____	Comments _____
High blood pressure (before age 50)	☐ 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 age 50)	☐ Yes	☐ No	Who _____	Comments _____
Bed-wetting (after age 10)	☐ 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	When _____
Problems with ears or hearing	☐ Yes	☐ No	When _____
Nasal allergies	☐ Yes	☐ No	When _____
Problems with eyes or vision	☐ Yes	☐ No	When _____
Asthma, bronchitis, bronchiolitis, pneumonia	☐ Yes	☐ No	When _____
Heart problems or heart murmur	☐ Yes	☐ No	When _____
Anemia or bleeding problem	☐ Yes	☐ No	When _____
Blood transfusion	☐ Yes	☐ No	When _____
Frequent abdominal pain	☐ Yes	☐ No	When _____
Constipation requiring doctor visits	☐ Yes	☐ No	When _____
Bladder or kidney infection	☐ Yes	☐ No	When _____
Bed-wetting (after age 5)	☐ Yes	☐ No	When _____
(For girls) Has she started menstrual cycle?	☐ Yes	☐ No	When _____
(For girls) Are there problems with her period?	☐ Yes	☐ No	When _____
Chronic/recurrent skin problem (acne, eczema)	☐ Yes	☐ No	When _____
Frequent headaches	☐ Yes	☐ No	When _____
Convulsions or other neurological problem	☐ Yes	☐ No	When _____
Diabetes	☐ Yes	☐ No	When _____
Thyroid or other endocrine problem	☐ Yes	☐ No	When _____
Any other significant problem	☐ Yes	☐ No	When _____
Use of alcohol or drugs	☐ Yes	☐ No	When _____