YOUNGSVILLE PEDIATRICS, LLC

INITIAL HISTORY QUESTIONNAIRE

Name
ID number
Birth date Age M F

Form Completed By Date

HOUSEHOLD

Please list all those living in child's home.

name	birth date	relationship to pt	health problems

Are there any siblings not listed? If so please list.

If mother and father are not living together or if child does not live with parents what is child's status?

BIRTH HISTORY

Birth weight_____ Was delivery O Vaginal O Caesarean?

Was the baby born at term?_____ Early?__ Late?___ If caesarean, why?_____

If early, how many weeks gestation?_____

Did your baby have any problems right after birth?

Did mother have any illness or problem with her pregnancy?
O YES O NO Explain_____

Was initial feeding O Breast O Bottle?

During pregnancy did mother
smoke? O YES O No alcohol? O YES O NO
Use drug or medications? O YES O NO

Did baby go home with mother from the hospital?
O YES O NO explain_____

GENERAL

			Explain
Do you consider your child in good health?	O YES	O NO	
Does your child have any serious illness or medical condition?	O YES	O NO	
Has your child had any serious injuries or accidents?	O YES	O NO	
Had your child ever been hospitalized?	O YES	O NO	
Is your child allergic to any medication or drugs?	O YES	O NO	

DEVELOPMENT

Are you concerned about your child's physical development?
Are you concerned about your child's mental or emotional development?
Are you concerned about your child's attention span?
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?

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FAMILY HISTORY

Have any family members had the following?			WHO
Deafness	O YES	O NO	WHO
Nasal Allergies	O YES	O NO	WHO
Asthma	O YES	O NO	WHO
Tuberculosis	O YES	O NO	WHO
Heart disease(before 50 yrs old)	O YES	O NO	WHO
High blood pressure(before 50 yrs old)	O YES	O NO	WHO
High cholesterol	O YES	O NO	WHO
Anemia	O YES	O NO	WHO
Bleeding Disorder	O YES	O NO	WHO
Liver disease	O YES	O NO	WHO
Kidney disease	O YES	O NO	WHO
Diabetes(before age 50)	O YES	O NO	WHO
Bed-wetting (after 10 yrs old)	O YES	O NO	WHO
Epilepsy or convulsions	O YES	O NO	WHO
Alcohol abuse	O YES	O NO	WHO
Drug abuse	O YES	O NO	WHO
Mental illness	O YES	O NO	WHO
Mental retardation	O YES	O NO	WHO
Immune problems, HIV, or AIDS	O YES	O NO	WHO
Additional family history	O YES	O NO	WHO

PAST HISTORY

Does your child have, or has he/she ever had:			Explain
Chickenpox	O YES	O NO	Explain
Frequent ear infections	O YES	O NO	Explain
Problems with ears or hearing	O YES	O NO	Explain
Nasal allergies	O YES	O NO	Explain
Problems with eyes or vision	O YES	O NO	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	O YES	O NO	Explain
Any heart problems or heart murmur	O YES	O NO	Explain
Anemia or bleeding problem	O YES	O NO	Explain
Blood transfusion	O YES	O NO	Explain
Frequent abdominal pain	O YES	O NO	Explain
Constipation requiring doctor visit	O YES	O NO	Explain
Bladder or kidney infection	O YES	O NO	Explain
Bed-wetting (after 5 yrs old)	O YES	O NO	Explain
(For girls) Has she started her menstrual cycle	O YES	O NO	Explain
(For girls) Are there problems with her periods	O YES	O NO	Explain
Any chronic or recurrent skin problems (acne, eczema,etc.)	O YES	O NO	Explain
Frequent headaches	O YES	O NO	Explain
Convulsion or other neurological problems	O YES	O NO	Explain
Diabetes	O YES	O NO	Explain
Thyroid or endocrine problem	O YES	O NO	Explain
Any other significant problem	O YES	O NO	Explain
Use of alcohol or drugs	O YES	O NO	Explain