Initial History Questionnaire

* **Patient's Name**

* **Date of Birth** **Today's Date**

Instructions

You and your child's health care team can work together towards better health. Please answer these questions as best as you can by filling the bubble next to your answer. You may skip a question if you don't know the answer or do not wish to answer. You may talk with your provider about any questions. Your answer will be protected as part of your child's medical record.

Sample Question and Answer: *Does your child go to school?* ● ***Yes*** ***o No***

General- Answer Yes or No. If No on 1, please explain. If Yes on 2-6, please Explain.

1.Do you consider your child to be in good health?	O Yes	O No	Explain _____
2. Does your child have any serious illness or medical condition?	O Yes	O No	Explain _____
3. Has your child had serious injuries or accidents?	O Yes	O No	Explain _____
4. Has your child had any surgery?	O Yes	O No	Explain _____
5. Has your child ever been hospitalized?	O Yes	O No	Explain _____
6. Is your child allergic to any medicines or drugs?	O Yes	O No	Explain _____

Family History

Does any of the patient's family members listed below have any of the following medical conditions? ***If none, please mark HEALTHY.***	**HEALTHY**	Anemia	Asthma	Cancer	Diabetes (before 50 years old)	Drug or Alcohol Abuse	Epilepsy or convulsions	Heart Disease (before 50 years old)	High Blood Pressure (before 50 years old)	High cholesterol	Mental illness	Tuberculosis
Mother	O	O	O	O	O	O	O	O	O	O	O	O
Father	O	O	O	O	O	O	O	O	O	O	O	O
Siblings	O	O	O	O	O	O	O	O	O	O	O	O
Maternal Grand Father	O	O	O	O	O	O	O	O	O	O	O	O
Maternal Grand Mother	O	O	O	O	O	O	O	O	O	O	O	O
Paternal Grand Father	O	O	O	O	O	O	O	O	O	O	O	O
Paternal Grand Mother	O	O	O	O	O	O	O	O	O	O	O	O

Past History - Answer Yes or No. If Yes, please Explain.

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

ADHD (Attention Deficit Hyperactivity Disorder)	○ Yes	○ No	Explain _____
Allergies (food, pets, dust, pollen)	○ Yes	○ No	Explain _____
Anemia or bleeding problem	○ Yes	○ No	Explain _____
Any chronic or recurrent skin problems (acne, eczema, etc.)	○ Yes	○ No	Explain _____
Any heart problem or heart murmur	○ Yes	○ No	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	○ Yes	○ No	Explain _____
Autism	○ Yes	○ No	Explain _____
Bed-wetting (after 5 years old)	○ Yes	○ No	Explain _____
Bladder or kidney infection	○ Yes	○ No	Explain _____
Blood transfusion	○ Yes	○ No	Explain _____
Chickenpox	○ Yes	○ No	Explain _____
Constipation requiring doctor visits	○ Yes	○ No	Explain _____
Convulsion or other neurologic problem (i.e. seizure, epilepsy)	○ Yes	○ No	Explain _____
Depression or emotional problems	○ Yes	○ No	Explain _____
Diabetes	○ Yes	○ No	Explain _____
(For girls) Has she started her menstrual period?	○ Yes	○ No	Explain _____
(For girls) Are there problems with her periods?	○ Yes	○ No	Explain _____
Frequent abdominal pain	○ Yes	○ No	Explain _____
Frequent ear infections	○ Yes	○ No	Explain _____
Frequent headaches	○ Yes	○ No	Explain _____
Poor school performance	○ Yes	○ No	Explain _____
Problems with ears or hearing	○ Yes	○ No	Explain _____
Problems with eyes or vision	○ Yes	○ No	Explain _____
Speech/Language/Development problems	○ Yes	○ No	Explain _____
Thyroid or other endocrine problem (i.e. high cholesterol)	○ Yes	○ No	Explain _____
Use of alcohol or drugs	○ Yes	○ No	Explain _____
Any other significant problem	○ Yes	○ No	Explain _____