



Pediatric Healthcare

### Initial History Questionnaire

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_ Male \_\_\_ Female \_\_\_

Form Completed By \_\_\_\_\_ Date \_\_\_\_\_

#### HOUSEHOLD

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

Name	Relationship	Birth Date	Health Problems
Are there siblings not listed? If yes, please list their names and ages and where they are:			
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

Was the baby born at:	<input type="checkbox"/> Term <input type="checkbox"/> Early <input type="checkbox"/> Late
If early, how many weeks gestation?	
Did mother have any illness or problem with her pregnancy?	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
During pregnancy did mother smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Use Drugs or medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
What?	
When?	
Was the delivery:	<input type="checkbox"/> Vaginal <input type="checkbox"/> Cesarean
If Cesarean, why?	
Did your baby have any problems right after birth?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Explain:	
Was Initial feeding:	<input type="checkbox"/> Breast <input type="checkbox"/> Bottle
Did your baby go home with mother from the hospital?	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain

## Initial History Questionnaire

### GENERAL

<b>Do you consider your child to be in good health?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Does your child have any serious illness or medical condition?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Has your child had serious injuries or accidents?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Has your child had any surgery?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Has your child ever been hospitalized?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Is your child allergic to any medicines or drugs?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain

### DEVELOPMENT

<b>Are you concerned about your child's physical development?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Are you concerned about your child's mental or emotional development?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>Are you concerned about your child's attention span?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No   Explain
<b>If your child is in school:</b>	
<b>How is his/her behavior in school?</b>	
<b>Has he/she failed or repeated a grad in school?</b>	
<b>How is he/she doing in academic subjects?</b>	
<b>Is he/she in special or resource classes?</b>	