

# Initial History Questionnaire

PATIENT NAME \_\_\_\_\_

GUARANTOR \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE \_\_\_\_\_

M F

## HOUSEHOLD

Please list all those living in the child's home

NAME	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If so, 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 of 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 baby born at term?  Yes  Early  Late

If early, how many week's gestation? \_\_\_\_\_

Did mother have any illness or problem with her pregnancy?

Yes  No Explain \_\_\_\_\_

During pregnancy, did mother

Smoke?  Yes  No Drink alcohol?  Yes  No

Use drugs or medications?  Yes  No

What \_\_\_\_\_ When \_\_\_\_\_

Was 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 an 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 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 or emotional development?  Yes  No Explain \_\_\_\_\_

Are you concerned about your child's attention span?  Yes  No Explain \_\_\_\_\_

Is your child in school?  Yes  No Explain \_\_\_\_\_

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? \_\_\_\_\_



**PEDIATRIC &  
ADOLESCENT  
ASSOCIATES, P.S.C.**

3050 Harrodsburg Road Lexington, KY 40503

## FAMILY HISTORY

Has any family members had the following:

- |  |                              |                             |           |                |
|--|------------------------------|-----------------------------|-----------|----------------|
| Deafness?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Nasal allergies?                           | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Asthma?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Tuberculosis?                              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Heart disease (before 50 years old)?       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High blood pressure (before 50 years old)? | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| High cholesterol?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Anemia?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bleeding disorder?                         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Liver disease?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Kidney disease?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Diabetes (before 50 years old)?            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old)?          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Epilepsy or convulsions?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Alcohol abuse?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Drug abuse?                                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental illness?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Mental retardation?                        | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |
| Immune problems, HIV or AIDS?              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Who _____ | Comments _____ |

Additional family history

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## PAST HISTORY

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

- |  |                              |                             |            |
|--|------------------------------|-----------------------------|------------|
| Chickenpox?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent ear infections?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Problems with ears or hearing?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Nasal allergies?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Problems with eyes or vision?                                  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Any heart problem or heart murmur?                             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Anemia or bleeding problem?                                    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Blood transfusion?   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent abdominal pain?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Constipation requiring doctor visits?                          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Bladder or kidney infection?                                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Bed-wetting (after 5 years old)?                               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| (For girls) Has she started her menstrual periods?             | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| (For girls) Are there problems with her periods?               | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Any chronic or recurrent skin problem?<br>(Acne, Eczema, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Frequent headaches?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Convulsions or other neurologic problem?                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Diabetes?  | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Thyroid or other endocrine problem?                            | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Any other significant problem?                                 | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |
| Use of alcohol or drugs?                                       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | When _____ |