

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

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, ages, and where they live. \_\_\_\_\_

What is the child's living situation if not with both biological parents?

- Lives with adoptive parents    Joint custody    Single custody  
 Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? \_\_\_\_\_

## Birth History Don't know birth history

Birth weight \_\_\_\_\_ Was the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ weeks

Were there any prenatal or neonatal complications?

Yes    No   Explain \_\_\_\_\_

Was a NICU stay required?    Yes    No   Explain \_\_\_\_\_

During pregnancy, did mother

Use tobacco    Yes    No   Drink alcohol    Yes    No

Use drugs or medications    Yes    No    Used prenatal vitamins

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

Was the delivery    Vaginal    Cesarean   If cesarean, why? \_\_\_\_\_

Was initial feeding    Formula    Breast milk   How long breastfed? \_\_\_\_\_

Did your baby go home with mother from the hospital?

Yes    No   Explain \_\_\_\_\_

## General DK = don't know

Do you consider your child to be in good health?    Yes    No    DK   Explain \_\_\_\_\_

Does your child have any serious illnesses or medical conditions?    Yes    No    DK   Explain \_\_\_\_\_

Has your child had any surgery?    Yes    No    DK   Explain \_\_\_\_\_

Has your child ever been hospitalized?    Yes    No    DK   Explain \_\_\_\_\_

Is your child allergic to medicine or drugs?    Yes    No    DK   Explain \_\_\_\_\_

Do you feel your family has enough to eat?    Yes    No    DK   Explain \_\_\_\_\_

## Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics



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