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| **Our Kids Pediatrics Initial History Questionnaire** | | | |
| Patient’s Name Birthdate | | | |
| **Household** | | | |
| Please list all of those living in the child’s home. | | | |
| Name | Relationship to child | Birthdate | Health Problems |
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| **Birth History** | | | |

Birth weight \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was the delivery Vaginal \_\_\_\_ Cesarean \_\_\_\_? Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_ If cesarean, why? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ If early, how many weeks gestation? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did your baby have any problems right after birth? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Did mother have any illness of problem with her pregnancy? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was initial feeding Breast \_\_\_\_ Bottle\_\_\_\_ During pregnancy did mother smoke? Yes \_\_\_ No \_\_\_ Drink alcohol? Yes \_\_\_ No \_\_\_\_ Use drugs or medications? Yes \_\_\_ No \_\_\_ What? \_\_\_\_\_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_ Did your baby go home with mother from hospital? Yes \_\_\_ No \_\_\_ Explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **General** |

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

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| **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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 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: Deafness Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nasal allergies Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Tuberculosis Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Heart disease (before age 50) Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High blood pressure (before age 50) Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ High cholesterol Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anemia Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bleeding disorder Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Liver disease Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes (before age 50) Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bed-wetting (after age 10) Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Epilepsy or convulsions Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alcohol abuse Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Drug abuse Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental illness Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mental retardation Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Immune problem, HIV or AIDS Yes \_\_ No \_\_ Who \_\_\_\_\_\_\_\_\_\_\_ Comments \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Additional family history \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| **Past History** |

Does your child have or has he/she ever had: Chickenpox Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequent ear infections Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems with ears or hearing Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nasal allergies Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Problems with eyes or vision Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Asthma, bronchitis, bronchiolitis/pneumonia Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any heart problems or heart murmur Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Anemia or bleeding problem Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood transfusion Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Frequent abdominal pain Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Constipation requiring doctor visits Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bladder or kidney infection Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bed-wetting (after age 5) Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Girls) Has she started her menstrual period? Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any chronic or recurrent skin problem Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (acne, eczema, etc.) Frequent headaches Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Convulsions or other neurologic problem Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Diabetes Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Thyroid or other endocrine problem Yes \_\_ No \_\_ When \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Any other significant problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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