

PEDIATRIC ASSOCIATES OF MICHIANA

INITIAL HISTORY QUESTIONNAIRE

Patient Name _____ DOB _____ Age _____

Form Completed By _____ Date Completed _____

HOUSEHOLD : Please list all those living in the child's home:

Name	Relationship to Child	Birthdate	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 the 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: Did mother have any illness or problem with her pregnancy? Yes No
If yes, please explain: _____

During the pregnancy, did mother:

Smoke? Yes No Drink alcohol? Yes No Use drugs or medications? Yes No
What _____ When _____

Was the delivery: Vaginal? Cesarean? (Why? _____)

Birth Weight: Was the baby born at Term Early Late If early, how many weeks' gestation? _____

Which Hospital was your baby born at? _____

Did your baby receive the Hepatitis B vaccine in the Hospital? Yes No Did your baby pass the Hearing Screening? Yes No

Did your baby have any problems right after birth: Yes No Was a NICU stay required? Yes No

If yes, please explain: _____

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 _____

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? _____

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

	Yes	No	When/Explain
Chickenpox			
Frequent ear infections			
Problems with ears or hearing			
Nasal allergies			
Problems with eyes or vision			
Asthma, bronchitis, Bronchiolitis or pneumonia			
Any heart problem or heart murmur			
Anemia or bleeding problem			
Convulsions or other neurologic problem			
Bed-wetting (after 5 years old)			
(For girls) Has started her menstrual period?			
(For girls) Are there problems with her periods?			
Any other significant problem			

FAMILY HISTORY: Have any family members had the following?

	Yes	No	Who	Comments
Asthma				
Diabetes				
Epilepsy or convulsions				
Tuberculosis				
Heart disease (before 50 years old)				

Additional family history _____

Parent or Guardian Signature _____ **Date** _____

Physician Signature _____ **Date** _____