Pediatric Associates of Michiana

Excellence in Children's Health

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:_____

_____

Is 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	Mother	Father	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Sibling
Asthma									
Diabetes									
Epilepsy or convulsions									
Tuberculosis									
Heart disease (before 50 years old)									

Additional family history_____

_____

Parent or Guardian Signature _____ **Date**_____

Physician Signature _____ **Date**_____