Initial History Questionnaire

Date: _____

Patient Name: _____ **Form Completed By:** _____

DOB: _____ **Relationship to Child:** _____

Gender: _____ **Signatures:** _____

Who does the child live with?

Both Biological Parents ☐ Adoptive Parents☐ Foster Parents☐ Joint Custody☐

Single Custody☐

Birth History

Birth weight _____ Was the baby born at term? Yes or No _____ Weeks

Delivery Type Vaginal☐ Cesarean☐

If any prenatal or neonatal complications, please explain _____

_____

If NICU stay was required, please explain _____

_____

Initial Feeding: Formula☐ Breast Milk☐ Combination☐ How long breastfed?_____

During Pregnancy, did mother:

Use tobacco Yes☐ No☐ Consume Alcohol Yes☐ No☐ Use Drugs or Medications Yes☐ No☐

Use Prenatal Vitamins Yes☐ No☐

Triangle Kids CARE PEDIATRICS

General Information

Do you consider your child to be in good health? Yes☐ No☐ Comments_____

_____

Does your child have any serious medical condition? Yes☐ No☐ Comments_____

_____

Has your child had any surgery? Yes☐ No☐ Comments_____

_____

Has your child ever been hospitalized? Yes☐ No☐ Comments_____

_____

Is your child allergic to any medications? Yes☐ No☐ Comments_____

_____

Biological Family History

Have any family members had the following:

Childhood hearing Loss	Yes☐	No☐	Who_____	Comments_____
Nasal allergies	Yes☐	No☐	Who_____	Comments_____
Asthma	Yes☐	No☐	Who_____	Comments_____
Tuberculosis	Yes☐	No☐	Who_____	Comments_____
Heart disease	Yes☐	No☐	Who_____	Comments_____
High Cholesterol	Yes☐	No☐	Who_____	Comments_____
Anemia	Yes☐	No☐	Who_____	Comments_____
Dental Decay	Yes☐	No☐	Who_____	Comments_____
Liver disease	Yes☐	No☐	Who_____	Comments_____
Kidney disease	Yes☐	No☐	Who_____	Comments_____
Obesity	Yes☐	No☐	Who_____	Comments_____
Alcohol Abuse	Yes☐	No☐	Who_____	Comments_____
Drug Abuse	Yes☐	No☐	Who_____	Comments_____
Depression	Yes☐	No☐	Who_____	Comments_____
Developmental disability	Yes☐	No☐	Who_____	Comments_____
Immune problems (HIV or AIDS)	Yes☐	No☐	Who_____	Comments_____
Tobacco use	Yes☐	No☐	Who_____	Comments_____

Additional Family History_____

_____

Triangle Kids CARE PEDIATRICS

Child's History

Does your child have, or has your child ever had:

Chickenpox	Yes☐	No☐	Comments_____
Frequent ear infections	Yes☐	No☐	Comments_____
Ear or Hearing problems	Yes☐	No☐	Comments_____
Nasal allergies	Yes☐	No☐	Comments_____
Eyes or vision issues	Yes☐	No☐	Comments_____
Asthma	Yes☐	No☐	Comments_____
Bronchitis, bronchiolitis	Yes☐	No☐	Comments_____
Pneumonia	Yes☐	No☐	Comments_____
Heart problem/murmur	Yes☐	No☐	Comments_____
Anemia or bleeding problem	Yes☐	No☐	Comments_____
Blood transfusion	Yes☐	No☐	Comments_____
Organ transplant	Yes☐	No☐	Comments_____
Frequent abdominal pain	Yes☐	No☐	Comments_____
Malignancy/ Bone Marrow Transplant	Yes☐	No☐	Comments_____
Chemotherapy	Yes☐	No☐	Comments_____
Constipation requiring doctors visit	Yes☐	No☐	Comments_____
Recurrent Urinary tract infection/Problems	Yes☐	No☐	Comments_____
Metabolic/Genetic Disorders	Yes☐	No☐	Comments_____
Cancer	Yes☐	No☐	Comments_____
Kidney disease	Yes☐	No☐	Comments_____
Urologic malformations	Yes☐	No☐	Comments_____
Bed wetting (after 5 years age)	Yes☐	No☐	Comments_____
Sleep problems; snoring	Yes☐	No☐	Comments_____
Recurring skin problems (Acne, eczema)	Yes☐	No☐	Comments_____
Frequent headaches	Yes☐	No☐	Comments_____
Neurologic problems	Yes☐	No☐	Comments_____
Obesity	Yes☐	No☐	Comments_____
Diabetes	Yes☐	No☐	Comments_____
Thyroid/Endocrine problems	Yes☐	No☐	Comments_____
High blood pressure	Yes☐	No☐	Comments_____
Serious Injuries/fractures/concussions	Yes☐	No☐	Comments_____
ADHD/anxiety/depression	Yes☐	No☐	Comments_____
Developmental delay	Yes☐	No☐	Comments_____
Dental decay	Yes☐	No☐	Comments_____
History of family violence	Yes☐	No☐	Comments_____

Triangle Kids CARE PEDIATRICS

Sexually transmitted infections Yes☐ No☐ Comments_____

Pregnancy Yes☐ No☐ Comments_____

(For girls) Problems with her periods Yes☐ No☐ Comments_____

Has had first period Yes☐ No☐ Age of first period_____

Any other significant problem(s)_____

_____