CARING HANDS PEDIATRICS PC

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INITIAL HISTORY QUESTIONNAIRE

Patient Name_____ DOB_____ Nickname_____

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 not in the home?_____

BIRTH HISTORY: Did mother have any illness or problem during the 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 (age of pregnancy)_____

Was the delivery: Vaginal? Caesarean? (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 nave 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_____
Is your child allergic to food or other? 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 you child is in school:

What grade is he/she in? _____

How is his/her behavior 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 infection			
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
Asthma			
Diabetes (before 55 Year old)			
Epilepsy or convulsions			
Tuberculosis			
Heart disease (before 55 years old)			
Childhood Hearing loss			
Sudden death			
High Cholesterol			
Anemia			
Bleeding Problems			
Cancer Before age 55			
Liver Disease			
Kidney Disease			
Epilepsy			
Alcohol/Drug Abuse			
Mental Illness/Depression			
Tobacco use			
Developmental Disability			
Immune Problems /HIV/AIDS			

Additional family history:_____

_____

Parent or Guardian Signature_____ Date_____

Physician Signature_____ Date_____