Initial History Questionnaire

CHILD'S NAME: _____ | DOB _____
FORM COMPLETED BY: _____

Household

What is the child's living situation?
Lives with:
___ Biological Parents ____ Adoptive Parents
___ Foster Family ____ Joint Custody
___ Single Custody (if so, who do they live with: _____)
___ Other: _____

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

Name:	Relationship to Child:	Birth Date:	Health Problems:

Birth History ___ I do not know the birth history

Born at _____ weeks and was delivered by _____ (vaginal or cesarean).
If cesarean, why? _____
Was the baby breech? Yes No
Was the baby conceived by IVF or other forms of assisted fertility? Yes No
If yes, did you use a donor egg or donor sperm? _____
Were there any prenatal or neonatal complications? Yes No
Explain: _____
Any prenatal ultrasound abnormalities? Yes No
Explain: _____
Was a NICU stay required? Yes No
Explain: _____

Infant currently feeding by Formula or Breast Milk

During pregnancy, did mother:
Use tobacco Yes No
Drink alcohol Yes No
Use drugs Yes No
Use Prenatal Vitamins Yes No
Take medication Yes No
Explain:_____

Any other information you feel the pediatrician should know?

_____

Biological Family History

___ I do not know the birth history

Have any family members had the following? (Please check the box that applies)

	Yes	No	Do not know	Who	Comments
Food Allergies					
Nasal allergies					
Asthma					
Bedwetting (after 6 years old)					
Dental Decay					
Childhood hearing loss					
Epilepsy/Seizures					
Developmental Disabilities					
Autism/Cognitive Delay					
ADHD					
Immune Problems, HIV					
Tuberculosis					
Thyroid Problems or other Endocrine Disease					
Autoimmune Disease					
Anemia					
Genetic or Heritable Disease					

Biological Family History

Continued

Have any family members had the following? (Please check the box that applies)

	Yes	No	Do not know	Who	Comments
Bleeding or Blood Disorder					
Liver Disease					
Kidney Disease					
Heart Disease					
Hypertension					
High Cholesterol or takes cholesterol medication					
Diabetes					
Obesity					
Cancer (before age 55)					
Depression					
Anxiety					
Eating Disorder					
Other Mental Illness					
Alcohol Abuse					
Tobacco Abuse					
Substance Abuse					

American Academy of Pediatrics

"The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate."