

**Pediatric Associates of Kingston**  
Initial History Questionnaire

Name \_\_\_\_\_ Chart # \_\_\_\_\_

DOB \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_

Form completed by: \_\_\_\_\_ Date Completed \_\_\_\_\_

**PLEASE LIST ALL THOSE LIVING IN THE CHILD'S HOME.**

	<u>Name</u>	<u>Relationship to child</u>	<u>DOB</u>	<u>Health Problems</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____

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 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**

Birth weight \_\_\_\_\_ was the delivery \_\_\_\_\_ vaginal \_\_\_\_\_ cesarean?

If cesarean, why? \_\_\_\_\_

Was the baby born at term? \_\_\_\_\_ early? \_\_\_\_\_ late? If early, how many weeks gestations? \_\_\_\_\_

Did your baby have any problems right after birth? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain \_\_\_\_\_

Was initial feeding \_\_\_\_\_ Breast? \_\_\_\_\_ Bottle?

Did your baby go home with mother from the hospital? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain \_\_\_\_\_

Did mother have any illness or problem with her pregnancy? \_\_\_\_\_ Yes \_\_\_\_\_ No

Explain \_\_\_\_\_

During pregnancy, did mother smoke \_\_\_\_\_ Yes \_\_\_\_\_ No

Drink alcohol \_\_\_\_\_ Yes \_\_\_\_\_ No Use drugs or medications \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, what and when \_\_\_\_\_

**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

**DEVELOPMENT**

Are you concerned about your child's physical development? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you concerned about your child's mental or emotional development? \_\_\_\_\_ Yes \_\_\_\_\_ No

Are you concerned about your child's attention span? \_\_\_\_\_ Yes \_\_\_\_\_ No

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? \_\_\_\_\_

**FAMILY HISTORY**

HAVE ANY FAMILY MEMBERS HAD THE FOLLOWING: (If yes, please list who)

Deafness	_____ Yes _____ No	Who _____
Nasal allergies	_____ Yes _____ No	Who _____
Asthma	_____ Yes _____ No	Who _____
Tuberculosis	_____ Yes _____ No	Who _____
Heart disease (before 50 yrs. old)	_____ Yes _____ No	Who _____
High blood pressure (before 50 yrs old)	_____ Yes _____ No	Who _____
High cholesterol	_____ Yes _____ No	Who _____
Anemia	_____ Yes _____ No	Who _____
Bleeding disorder	_____ Yes _____ No	Who _____
Liver disease	_____ Yes _____ No	Who _____
Kidney disease	_____ Yes _____ No	Who _____
Diabetes (before 50 yrs. old)	_____ Yes _____ No	Who _____
Bed-wetting (after 10 yrs. old)	_____ Yes _____ No	Who _____
Epilepsy or convulsions	_____ Yes _____ No	Who _____
Alcohol Abuse	_____ Yes _____ No	Who _____
Drug Abuse	_____ Yes _____ No	Who _____
Mental illness	_____ Yes _____ No	Who _____
Mental retardation	_____ Yes _____ No	Who _____
Immune problems, HIV, of AIDS	_____ Yes _____ No	Who _____
Additional family history	_____	

**PAST HISTORY**

DOES YOUR CHILD HAVE, OR HAS HE/SHE EVER HAD: (If yes, please explain)

Chickenpox	_____ Yes _____ No	Explain _____
Frequent ear infections	_____ Yes _____ No	Explain _____
Problems with ears or hearing	_____ Yes _____ No	Explain _____
Nasal allergies	_____ Yes _____ No	Explain _____
Problems with eyes or vision	_____ Yes _____ No	Explain _____
Asthma, bronchitis, broncholitis, or pneumonia	_____ Yes _____ No	Explain _____
Any heart problem or heart murmur	_____ Yes _____ No	Explain _____
Anemia or bleeding problem	_____ Yes _____ No	Explain _____
Blood transfusion	_____ Yes _____ No	Explain _____
Frequent abdominal pain	_____ Yes _____ No	Explain _____
Constipation requiring doctor visits	_____ Yes _____ No	Explain _____
Bladder or kidney infection	_____ Yes _____ No	Explain _____
Bed-wetting (after 5 yrs. old)	_____ Yes _____ No	Explain _____
(For girls) Has she started her menstrual period?	_____ Yes _____ No	When _____
(For girls) Are there problems with her periods?	_____ Yes _____ No	Explain _____
Any chronic or recurrent skin problem	_____ Yes _____ No	Explain _____
Frequent headaches	_____ Yes _____ No	Explain _____
Convulsions or other neurologic problem	_____ Yes _____ No	Explain _____
Diabetes	_____ Yes _____ No	Explain _____
Thyroid or other endocrine problem	_____ Yes _____ No	Explain _____
Any other significant problem	_____ Yes _____ No	Explain _____
Use of alcohol or drugs	_____ Yes _____ No	Explain _____