Initial History Questionnaire

Georgetown Pediatrics, PSC

Name: _____ DOB: _____ Age: _____

Form Completed By: _____ Date Completed: _____

HOUSEHOLD Please list all people living in the child's home:

Name	Relationship to Child	DOB	Health Problems

Are there any siblings not listed? ☐ Yes ☐ No

If so, please list their names, 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(s) not in the home?

_____

BIRTH HISTORY

Birth Weight: _____ Was the baby born ☐ At term? ☐ Early? ☐ Late? If early, how many weeks gestation? _____

Was the delivery ☐ Vaginal? ☐ Cesarean? If cesarean, why? _____

Did your baby have any problems right after birth? ☐ 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 What_____ When_____

Was initial feeding ☐ Breast? ☐ Bottle?

Did baby go home with mom from hospital? ☐ Yes ☐ No Explain_____

Where was your baby born? _____ Was the Hepatitis B vaccine administered? ☐ Yes ☐ No

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/emotional development? ☐ Yes ☐ No Explain_____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain_____

Does he/she have any specific communication needs (hearing, vision or cognitive issues)?

☐ Yes ☐ No Explain_____

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/SOCIAL/CULTURAL CHARACTERISTICS

We can better care for your child if we know of any family, social or cultural characteristics that affect you or your child.

Is there anything we should know concerning your family or household structure that might affect your child's care?

Examples could include but are not limited to recent divorce or custody issues, recent moves, serious illness of a parent or other family member, a new step parent or step siblings.

☐ Yes ☐ No
Explain_____

Is there anything we should know concerning your child's social situation that might affect your child's care?

Examples could include but are not limited to parental unemployment, exposure to violence or drug abuse, bullying, inadequate social support or food insecurity (not enough food to adequately feed your child).

☐ Yes ☐ No
Explain_____

Is there anything we should know concerning your child's cultural situation that might affect your child's care?

Examples could include but are not limited to religious beliefs concerning medical care, vaccination hesitancy, dietary needs, educational preferences or how your doctor interacts with your family.

☐ Yes ☐ No
Explain_____

OTHER CONCERNS

Is there anything else we need to know that would help us to provide the best care possible for you and your child?

☐ Yes ☐ No
Explain_____

FAMILY HISTORY

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who_____	Comments_____
Migraine	☐ Yes	☐ No	Who_____	Comments_____
Nasal Allergies	☐ Yes	☐ No	Who_____	Comments_____
Asthma	☐ Yes	☐ No	Who_____	Comments_____
Tuberculosis	☐ Yes	☐ No	Who_____	Comments_____
Congenital heart disease	☐ Yes	☐ No	Who_____	Comments_____
High blood pressure (before 50 years old)	☐ Yes	☐ No	Who_____	Comments_____
High cholesterol	☐ Yes	☐ No	Who_____	Comments_____
Anemia	☐ Yes	☐ No	Who_____	Comments_____
Bleeding disorder	☐ Yes	☐ No	Who_____	Comments_____
Liver disease	☐ Yes	☐ No	Who_____	Comments_____
Bed wetting (>10 years old)	☐ Yes	☐ No	Who_____	Comments_____
Kidney disease	☐ Yes	☐ No	Who_____	Comments_____
Diabetes (before 50 years old)	☐ Yes	☐ No	Who_____	Comments_____
Epilepsy or convulsions	☐ Yes	☐ No	Who_____	Comments_____
Alcohol abuse	☐ Yes	☐ No	Who_____	Comments_____
Drug abuse	☐ Yes	☐ No	Who_____	Comments_____
Mental illness (depression, anxiety, ADHD)	☐ Yes	☐ No	Who_____	Comments_____
ASD (Autism Spectrum Disorder)	☐ Yes	☐ No	Who_____	Comments_____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who_____	Comments_____
Cancer	☐ Yes	☐ No	Who_____	Comments_____
Ulcerative colitis/Crohns	☐ Yes	☐ No	Who_____	Comments_____
Developmental delay	☐ Yes	☐ No	Who_____	Comments_____
Genetic illness	☐ Yes	☐ No	Who_____	Comments_____
Sudden unexplained death in person <50	☐ Yes	☐ No	Who_____	Comments_____

Additional family history _____

PAST HISTORY

Does your child have, or has he/she ever had:

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, bronchiolitis, 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 years old)	☐ Yes	☐ No	Explain_____
Has she started her menstrual periods?	☐ Yes	☐ No	Explain_____
Are there problems with her periods?	☐ Yes	☐ No	Explain_____
Any chronic or recurrent skin problem	☐ Yes	☐ No	Explain_____
ASD (Autism Spectrum Disorder)	☐ 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_____
Mental illness (depression, anxiety, ADHD etc.)	☐ Yes	☐ No	Explain_____