Initial History Questionnaire	Name
FORM COMPLETED BY DATE COMPLETED	BIRTH DATE AGE M F

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	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 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?
Was the baby born at term? Early? Late?	If cesarean, why:
If early, how many weeks gestation?	Did your baby have any problems right after birth?
Did mother have any illness or problem with her pregnancy?	☐ Yes ☐ No Explain
☐ Yes ☐ No Explain:	
	Was initial feeding ☐ Breast? ☐ Bottle?
During pregnancy, did mother:	Did your baby go home with mother from the hospital?
Smoke ☐ Yes ☐ No Drink Alcohol ☐ Yes ☐ No	☐ Yes ☐ No Explain
Use drugs or medications ☐ Yes ☐ No	
What 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 accients?	☐ 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 or emotional development?	☐ Yes ☐ No Explain
Are you concerned about your child's attention span?	☐ Yes ☐ No Explain
If your child is in school:	☐ Yes ☐ No Explain
How is his/her behavior in school?	☐ Yes ☐ No Explain
Has he/she failed or repeated a grade in school?	☐ Yes ☐ No Explain
How is he/she doing in academic subject?	☐ Yes ☐ No Explain
Is he/she in special or resource classes?	☐ Yes ☐ No Explain

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Family History

Have any family members had the following:	☐ Yes ☐ No	Who	Comments
Deafness	☐ Yes ☐ No	Who	Comments
Nasal allergies	☐ Yes ☐ No	Who	Comments
Asthma	☐ Yes ☐ No	Who	Comments
Tuberculosis	☐ Yes ☐ No	Who	Comments
Heart disease (before 50 years old)	☐ 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
Kidney disease	☐ Yes ☐ No	Who	Comments
Diabetes (before 50 years old)	☐ Yes ☐ No	Who	Comments
Bed-wetting (after 10 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	☐ Yes ☐ No	Who	Comments
Mental retardation	☐ Yes ☐ No	Who	Comments
Immune problems, HIV, or AIDS	☐ Yes ☐ No	Who	Comments

Additional family history

Past History

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

	☐ Yes ☐ No	When / Explain
Chickenpox	☐ Yes ☐ No	When
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
Freequent 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
(For girls) Has she started her menstrual periods?	☐ Yes ☐ No	Explain
(For girls) Are there problems with her periods?	☐ Yes ☐ No	Explain
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ 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