Initial History Questionnaire

FORM COMPLETED BY _____ DATE COMPLETED _____

Springtime PEDIATRICS

Household

Are there siblings not listed? If so, please list their names, ages, and where they live. _____

_____

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

_____

Exposure to passive smoke in the home? ☐ Yes ☐ No

Are there guns in the home? ☐ Yes ☐ No
Are they safely secured? ☐ Yes ☐ No

Do you feel your family has enough to eat? ☐ Yes ☐ No
Explain _____

Birth History ☐ Don't know birth history

Birth weight_____Was the baby born at term?_____OR_____weeks

Were there any prenatal or neonatal complications?

☐ Yes ☐ No Explain _____

_____

Was a NICU stay required? ☐ Yes ☐ No Explain_____

_____

During pregnancy, did mother

Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins

What_____When _____

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

_____

_____

_____

Was initial feeding ☐ Formula ☐ Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital?

☐ Yes ☐ No Explain _____

_____

_____

_____

General DK = don't know

Do you consider your child to be in good health? ☐ Yes ☐ No ☐ DK Explain _____

_____

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain _____

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain _____

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain _____

Is your child allergic to medicine or drugs? ☐ Yes ☐ No ☐ DK Explain _____

Will a language or sign language interpreter be required for your visit? ☐ Yes ☐ No ☐ DK Explain _____

Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	Yes	No	DK	Who_____	Comments _____
Nasal allergies	Yes	No	DK	Who_____	Comments _____
Asthma	Yes	No	DK	Who_____	Comments _____
Tuberculosis	Yes	No	DK	Who_____	Comments _____
Heart disease (before 55 years old)	Yes	No	DK	Who_____	Comments _____
High cholesterol/takes cholesterol medication	Yes	No	DK	Who_____	Comments _____
Anemia	Yes	No	DK	Who_____	Comments _____
Bleeding disorder	Yes	No	DK	Who_____	Comments _____
Dental decay	Yes	No	DK	Who_____	Comments _____
Cancer (before 55 years old)	Yes	No	DK	Who_____	Comments _____

(Biological Family History continued on back side.)

(continued on next page…)

Biological Family History *(Continued from front side.)* DK = don't know

Liver disease	☐ Yes	☐ No	☐ DK	Who	Comments
Kidney disease	☐ Yes	☐ No	☐ DK	Who	Comments
Diabetes (before 55 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
Bed-wetting (after 10 years old)	☐ Yes	☐ No	☐ DK	Who	Comments
Obesity	☐ Yes	☐ No	☐ DK	Who	Comments
Epilepsy or convulsions	☐ Yes	☐ No	☐ DK	Who	Comments
Alcohol abuse	☐ Yes	☐ No	☐ DK	Who	Comments
Drug abuse	☐ Yes	☐ No	☐ DK	Who	Comments
Mental illness/depression	☐ Yes	☐ No	☐ DK	Who	Comments
Developmental disability	☐ Yes	☐ No	☐ DK	Who	Comments
Immune problems, HIV, or AIDS	☐ Yes	☐ No	☐ DK	Who	Comments
Tobacco use	☐ Yes	☐ No	☐ DK	Who	Comments

Additional family history _____

Past History DK = don't know

Does your child have, or has your child ever had,

Chickenpox	☐ Yes	☐ No	☐ DK	When
Frequent ear infections	☐ Yes	☐ No	☐ DK	Explain
Problems with ears or hearing	☐ Yes	☐ No	☐ DK	Explain
Nasal allergies	☐ Yes	☐ No	☐ DK	Explain
Problems with eyes or vision	☐ Yes	☐ No	☐ DK	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	☐ DK	Explain
Any heart problem or heart murmur	☐ Yes	☐ No	☐ DK	Explain
Anemia or bleeding problem	☐ Yes	☐ No	☐ DK	Explain
Blood transfusion	☐ Yes	☐ No	☐ DK	Explain
HIV	☐ Yes	☐ No	☐ DK	Explain
Organ transplant	☐ Yes	☐ No	☐ DK	Explain
Malignancy/bone marrow transplant	☐ Yes	☐ No	☐ DK	Explain
Chemotherapy	☐ Yes	☐ No	☐ DK	Explain
Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain
Recurrent urinary tract infections and problems	☐ Yes	☐ No	☐ DK	Explain
Congenital cataracts/retinoblastoma	☐ Yes	☐ No	☐ DK	Explain
Metabolic/Genetic disorders	☐ Yes	☐ No	☐ DK	Explain
Cancer	☐ Yes	☐ No	☐ DK	Explain
Kidney disease or urologic malformations	☐ Yes	☐ No	☐ DK	Explain
Bed-wetting (after 5 years old)	☐ Yes	☐ No	☐ DK	Explain
Sleep problems; snoring	☐ Yes	☐ No	☐ DK	Explain
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes	☐ No	☐ DK	Explain
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain
Obesity	☐ Yes	☐ No	☐ DK	Explain
Diabetes	☐ Yes	☐ No	☐ DK	Explain
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain
High blood pressure	☐ Yes	☐ No	☐ DK	Explain
History of serious injuries/fractures/concussions	☐ Yes	☐ No	☐ DK	Explain
Use of alcohol or drugs	☐ Yes	☐ No	☐ DK	Explain
Tobacco use	☐ Yes	☐ No	☐ DK	Explain
ADHD/anxiety/mood problems/depression	☐ Yes	☐ No	☐ DK	Explain
Developmental delay	☐ Yes	☐ No	☐ DK	Explain
Dental decay	☐ Yes	☐ No	☐ DK	Explain
History of family violence	☐ Yes	☐ No	☐ DK	Explain
Sexually transmitted infections	☐ Yes	☐ No	☐ DK	Explain
Pregnancy	☐ Yes	☐ No	☐ DK	Explain
(For girls) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem _____

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

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.

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