Initial History Questionnaire

PRIMARY CARE PEDIATRICS, PC

Name of patient: _____ **Date of Birth:** / / ☐ M ☐ F

FORM COMPLETED BY _____ DATE COMPLETED / /

Household

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

Name	Relationship to child	DOB	Health Problems

What is the child's living situation if not with both biological parents?
☐ Lives with adoptive parents ☐ Joint custody ☐ Single custody
☐ Lives with foster family

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 _____

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

During pregnancy, did mother
Use tobacco ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No
Use drugs or medications ☐ Yes ☐ No ☐ Used prenatal vitamins
What _____ When _____

General

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

Does your child have any medical conditions? ☐ 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 medicine? ☐ Yes ☐ No Explain _____

Biological Family History

Have any family members had the following?

Diabetes	☐ Yes	☐ No	Who _____
Epilepsy or convulsions	☐ Yes	☐ No	Who _____
Asthma	☐ Yes	☐ No	Who _____
Tuberculosis	☐ Yes	☐ No	Who _____
Heart disease (before 55 years old)	☐ Yes	☐ No	Who _____
High cholesterol/takes cholesterol medication	☐ Yes	☐ No	Who _____
Anemia	☐ Yes	☐ No	Who _____
Bleeding disorder	☐ Yes	☐ No	Who _____
Developmental Disability	☐ Yes	☐ No	Who _____