Patient Name_____ Date of Birth_____ Age _____

History Questionnaire

Social History

Parent's Name	Relationship to child	Date of Birth

Parent's Marital Status: **(Please circle one)**

Married **Divorced** **Separated** **Never Married**

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

_____

Parent's Occupation:
Father: _____

Mother:_____
Daytime Status: (Circle all that a apply)

Home Daycare School

Does anyone in the household smoke? ☐ Yes ☐No
Does anyone at daycare smoke? ☐ Yes ☐No
Are there pets in the home? ☐ Yes ☐No
Are there pets in the daycare? ☐ Yes ☐No

Please list all those living in the house

Name	Relationship to child	DOB of Siblings only

Are there firearms in the home? ☐ **Yes** ☐**No**

If yes: (Please check what applies)

☐ They are hidden away without gun locks.
☐ They are hidden away but have gun locks on them.
☐ They are locked up in a gun safe or cabinet.
☐ Other _____

Family History

Circle all that apply in your family history (Parents, Grandparents, Siblings, Aunts, Uncles & 1st Cousins of the patient)

Cancer Asthma Nasal Allergies Diabetes (before 50 years old) High Blood Pressure (before 50 years old) High Cholesterol

Heart Disease (before 50 years old) Rheumatologic Disease (Arthritis, Lupus, Thyroid Disease) Kidney Disease Liver Disease

Anemia Bleeding Disorder Mental Illness Epilepsy or seizures Alcohol Abuse Drug Abuse Deafness Tuberculosis

Bed-wetting (after 10 years old) Immune Problems HIV or AIDS Unexplained Sudden Death (before 50 years old)

Please tell us who has what history: Example: Dad –Cancer (throat) , Grandmother – bleeding disorder-(blood clots)

Birth History

Was the child adopted? ☐ Yes ☐ No

If yes, was it an international adoption? ☐ Yes ☐ No

If yes, from what country? _____

Birth Weight _____

How many weeks gestation?_____

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean , why? _____

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

If yes, explain? _____

_____

Was initial feeding ☐Breast? ☐Bottle?

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

If yes, explain _____

During pregnancy, did mother

Smoke? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No

Use drugs or medications? ☐ Yes ☐ No
If yes, what were they? _____

_____

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

If no, explain _____

_____

_____

Developmental History

Sat up: ☐Normal ☐Delayed ☐Unknown **Walked:** ☐Normal ☐Delayed ☐Unknown **Speech Development:** ☐Normal ☐Delayed ☐Unknown

Has your child ever been evaluated for or diagnosed with a developmental delay? ☐ Yes ☐ No
If yes, explain_____

If your child is in school:
How is he/she doing in academic subjects?_____
Is he/she in special or resource classes? ☐ Yes ☐ No
Has he/she failed or repeated a grade? ☐ Yes ☐ No
Has he/she been diagnosed with a learning disorder? ☐ Yes ☐ No

Past Medical History

Please list any previous surgeries or hospitalizations? (List month/year, hospital and type of surgery):

_____

_____

Please list any serious injuries or accidents?

_____

Any drug or food allergies? _____

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

Chicken pox	☐ Yes	☐ No	If yes when: _____		
Frequent ear infections	☐ Yes	☐ No	Bed-wetting (after 5 years old)	☐ Yes	☐ No
Problems with hearing or ears	☐ Yes	☐ No	Thyroid or other endocrine problem	☐ Yes	☐ No
Food or environmental allergies	☐ Yes	☐ No	Any chronic or recurrent skin problem	☐ Yes	☐ No
Problems with eyes or vision	☐ Yes	☐ No	(acne, eczema, etc)		
Asthma	☐ Yes	☐ No	Frequent headaches	☐ Yes	☐ No
Frequent bronchitis or pneumonia	☐ Yes	☐ No	Convulsions or other neurologic problem	☐ Yes	☐ No
Recurrent croup	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No
Other chronic or serious lung disease	☐ Yes	☐ No	Cancer	☐ Yes	☐ No
Tuberculosis or positive TB skin test	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
High blood pressure	☐ Yes	☐ No	Sexually transmitted disease	☐ Yes	☐ No
High cholesterol	☐ Yes	☐ No	Emotional disorder or suicide attempts	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Behavior disorder (ADHD, ODD)	☐ Yes	☐ No
Congenital or acquired heart defect	☐ Yes	☐ No	Psychiatric disorder	☐ Yes	☐ No
Anemia or bleeding problem	☐ Yes	☐ No	Use of alcohol or drugs	☐ Yes	☐ No
Blood transfusion	☐ Yes	☐ No	(For girls) Has she started her menstrual periods	☐ Yes	☐ No
Frequent abdominal pain	☐ Yes	☐ No	(For girls) Are there problems with her periods	☐ Yes	☐ No
Constipation requiring doctor visits	☐ Yes	☐ No	Other	☐ Yes	☐ No
Bladder or kidney infection	☐ Yes	☐ No			

Please explain any yes answers: _____

_____

PLEASE PROVIDE PATIENT'S IMMUNIZATION HISTORY FOR INITIAL VISIT