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:

Condition	Yes	No
Chicken pox	Yes	No
Frequent ear infections	Yes	No
Problems with hearing or ears	Yes	No
Food or environmental allergies	Yes	No
Problems with eyes or vision	Yes	No
Asthma	Yes	No
Frequent bronchitis or pneumonia	Yes	No
Recurrent croup	Yes	No
Other chronic or serious lung disease	Yes	No
Tuberculosis or positive TB skin test	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Heart murmur	Yes	No
Congenital or acquired heart defect	Yes	No
Anemia or bleeding problem	Yes	No
Blood transfusion	Yes	No
Frequent abdominal pain	Yes	No
Constipation requiring doctor visits	Yes	No
Bladder or kidney infection	Yes	No

If yes when: ______________________

Condition	Yes	No
Bed-wetting (after 5 years old)	Yes	No
Thyroid or other endocrine problem	Yes	No
Any chronic or recurrent skin problem (acne, eczema, etc)	Yes	No
Frequent headaches	Yes	No
Convulsions or other neurologic problem	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
HIV/AIDS	Yes	No
Sexually transmitted disease	Yes	No
Emotional disorder or suicide attempts	Yes	No
Behavior disorder (ADHD, ODD)	Yes	No
Psychiatric disorder	Yes	No
Use of alcohol or drugs	Yes	No
(For girls) Has she started her menstrual periods	Yes	No
(For girls) Are there problems with her periods	Yes	No
Other	Yes	No

Please explain any yes answers: ______________________

____

PLEASE PROVIDE PATIENT'S IMMUNIZATION HISTORY FOR INITIAL VISIT

PATIENT INFORMATION ☐ ☐ MUST BE FILLED OUT COMPLETELY

Patient's Name: ______________________________ (last) (first) (m.i.)

Patient's Address: ______________________________ (street #) (apt.# / lot #)

______________________________ (city) (state) (zip)

PLEASE BRING COMPLETED FORM TO YOUR FIRST VISIT

Sex: ☐ Male ☐ Female

D.O.B. ____________

S.S.# ____________

Home # ____________

Other childen seen at WPA ______________________________

PARENT INFORMATION

Father's Name: ______________________________ (last) (first) (m.i.)

Father's Address: ______________________________ (street #) (apt.# / lot #)

______________________________ (city) (state) (zip)

Relationship to patient: ☐ Father ☐ Stepfather ☐ Other ____________

Spouse: ____________ Father's Employer: ____________

D.O.B. ____________

S.S.# ____________

Home # ____________

Cell # ____________

Work # ____________

Email: ____________

Mother's Name: ______________________________ (last) (first) (m.i.)

Mother's Address: ______________________________ (street #) (apt.# / lot #)

______________________________ (city) (state) (zip)

Relationship to patient: ☐ Mother ☐ Stepmother ☐ Other ____________

Spouse: ____________ Mother's Employer: ____________

D.O.B. ____________

S.S.# ____________

Home # ____________

Cell # ____________

Work # ____________

Email: ____________

INSURANCE INFORMATION

Primary Insurance Co.: ______________________________ Effective Date: ____________

Policy Number: ____________ Group Number: ____________ Copay: ____________

Names of Policy Holder (employee): ______________________________ DOB: ____________

Relationship to patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other ____________

Secondary Insurance Co.: ______________________________ Effective Date: ____________

Policy Number: ____________ Group Number: ____________ Copay: ____________

Names of Policy Holder (employee): ______________________________ DOB: ____________

Relationship to patient: ☐ Father ☐ Mother ☐ Stepfather ☐ Stepmother ☐ Other ____________

I do hereby authorize the release of any medical information to process the medical claims and request payment of any medical benefits to be made to Wichita Pediatric Associates, PA. I understand that any services not covered or paid by my insurance company will be my responsibility.

Signed: X ______________________________ Date: ____________