WILLIS-KNIGHTON HEALTH SYSTEM

Initial History Questionnaire

_____
Form Completed By   Date Completed

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

Name	Relationship to child	Birth date	Health Problems

Birth History

Birth weight_____

Was the baby born at term? _____ Early?_____ Late?_____

If early, how many weeks gestation?_____

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

During pregnancy, did mother
Smoke: ☐ Yes ☐ No   Drink Alcohol: ☐ Yes ☐ No
Use drugs or medications:☐ Yes ☐ No
What_____ When_____

General

Do you consider your child to be in good health?

Does your child have any serious illness or medical condition?

Has your child had serious injuries or accidents?

Has your child had any surgery?

Has your child ever been hospitalized?

Is your child allergic to any medications or drugs?

Development
Are you concerned about your child's physical development?
Are you concerned about your child's mental or emotional health development?
Are you concerned about your child's attention span?
If your child is in school:

How is his/her behavior in school?_____

Has he/she failed or repeated a grade in school?_____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

Name_____
ID Number_____
Birth Date_____ Age_____   M   F

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 does he/she see the parent/parents not in the home?_____
_____

Was the delivery ☐ Vaginal?   ☐ Cesarean?

If cesarean, why?_____

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

Was initial feeding ☐ Breast?   ☐ Bottle?

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

☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____

☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____
☐ Yes ☐ No   Explain_____

HP0005

Family History

Have any family members had the following:

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:

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_____
Frequent 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   When _____
(For girls) Are there problems with her periods? ☐ Yes ☐ No   Explain_____
Any chronic or recurrent skin problems   ☐ Yes ☐ No   Explain_____
(acne, eczema, etc)
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_____

Initial History Questionnaire