WILLIS-KNIGHTON HEALTH SYSTEM

Initial History Questionnaire

Name _____
ID Number _____
Birth Date _____ Age _____ M F

_____
Form Completed By Date Completed

Household

Please list all those living in the child's home

Name	Relationship to child	Birth date	Health Problems

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?_____

_____

Birth History

Birth weight _____

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

Was the delivery ☐ Vaginal? ☐ Cesarean?

If early, how many weeks gestation?_____

If cesarean, why?_____

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

_____

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

_____

Was initial feeding ☐ Breast? ☐ Bottle?

During pregnancy, did mother
Smoke: ☐ Yes ☐ No Drink Alcohol: ☐Yes ☐ No
Use drugs or medications:☐Yes ☐ No
What _____ When _____

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

_____

General

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

Does your child have any serious illness or medical condition? ☐ Yes ☐ No Explain _____

Has your child had serious injuries or accidents? ☐ 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 any medications or drugs? ☐ Yes ☐ No Explain _____

Development

Are you concerned about your child's physical development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's mental or emotional health development? ☐ Yes ☐ No Explain _____

Are you concerned about your child's attention span? ☐ Yes ☐ No Explain _____

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? _____

HP0005

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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 (acne, eczema, etc)	☐ Yes ☐ No	Explain _____	
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 _____	

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HP0005