Carpenter Primary Healthcare

Initial Pediatric History Questionnaire

Patient Name:	Birth Date:
Age:	Gender : M F
Form Completed By:	Date Completed:

Household

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

Name	Relationship to the child	Birth Date	Health Problems

Are there siblings not listed? If so, please list their names, ages and where they live. _____
_____

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
If one or both parents are not living in the home, how often does the child see the parent(s) not at home?
_____
_____

Birth History ☐ Don't know birth history

Birth weight_____.Was the baby born at term? _____
Weeks:_____
Were there any prenatal complications?
❏Yes ❏No Explain_____
Was a NICU stay required? ❏Yes ❏ No Explain _____
_____
During pregnancy, did mother:
Use tobacco ❏ Yes ❏ No ❏ Use prenatal vitamins
What_____ When _____

Was the delivery ❏Vaginal ❏Cesarean   If cesarean, why?
_____
_____
_____
Was initial feeding ❏Formula ❏Breast milk
How long breastfed? _____
Did your baby go home with mother from hospital?
❏Yes ❏ No Explain _____
_____

General   DK= Don't know

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

Does your child have and serious illness or medical conditions? ❏Yes ❏ No ❏ DK Explain _____
_____

Has your child had any surgery? ❏Yes ❏No ❏DK Explain _____
_____

Has your child ever been hospitalized? ❏Yes ❏ No ❏ DK Explain _____
_____

Is your child allergic to any medicine or drugs? ❏Yes ❏No ❏DK Explain _____
_____

Is your child currently taking any medication? If so, please list name, dose, and how often _____
_____

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Have any family members had any of the following?

Childhood hearing loss	❏Yes ❏No ❏DK Who_____	Comments _____
Nasal Allergies	❏Yes ❏No ❏DK Who_____	Comments _____
Asthma	❏Yes ❏No ❏DK Who_____	Comments _____
Tuberculosis	❏Yes ❏No ❏DK Who_____	Comments _____
Heart Disease (before 50 yrs old)	❏Yes ❏No ❏DK Who_____	Comments _____
High Cholesterol	❏Yes ❏No ❏DK Who_____	Comments _____
Anemia	❏Yes ❏No ❏DK Who_____	Comments _____
Bleeding Disorder	❏Yes ❏No ❏DK Who_____	Comments _____
Liver Disease	❏Yes ❏No ❏DK Who_____	Comments _____
Kidney Disease	❏Yes ❏No ❏DK Who_____	Comments _____
Diabetes (before 50 yrs old)	❏Yes ❏No ❏DK Who_____	Comments _____
Bed-wetting (after 10 yrs old)	❏Yes ❏No ❏DK Who_____	Comments _____
Epilepsy or convulsions	❏Yes ❏No ❏DK Who_____	Comments _____
Alcohol Abuse	❏Yes ❏No ❏DK Who_____	Comments _____
Drug Abuse	❏Yes ❏No ❏DK Who_____	Comments _____
Tobacco Use	❏Yes ❏No ❏DK Who_____	Comments _____
Mental illness	❏Yes ❏No ❏DK Who_____	Comments _____
Immune problems, HIV, AIDS	❏Yes ❏No ❏DK Who_____	Comments _____

Additional Family History _____

_____

Does your child have, or has your child ever had,

Chicken Pox	❏Yes ❏No ❏DK When _____
Frequent Ear Infections	❏Yes ❏No ❏DK Explain_____
Problems with ears or hearing	❏Yes ❏No ❏DK Explain_____
Nasal Allergies	❏Yes ❏No ❏DK Explain_____
Problems with eyes or vision	❏Yes ❏No ❏DK Explain _____
Asthma, bronchitis or pneumonia	❏Yes ❏No ❏DK Explain _____
Any heart problem/murmur	❏Yes ❏No ❏DK Explain_____
Anemia or bleeding problem	❏Yes ❏No ❏DK Explain_____
Blood transfusion	❏Yes ❏No ❏DK Explain_____
Frequent abdominal pain	❏Yes ❏No ❏DK Explain_____
Constipation requiring doctor visit	❏Yes ❏No ❏DK Explain_____
Bladder or kidney infection	❏Yes ❏No ❏DK Explain_____
Bed-wetting (after 5 yrs old)	❏Yes ❏No ❏DK Explain_____
Chronic/recurrent skin problem	❏Yes ❏No ❏DK Explain_____
Frequent headaches	❏Yes ❏No ❏DK Explain_____
Convulsions/ other neurologic problem	❏Yes ❏No ❏DK Explain_____
Diabetes	❏Yes ❏No ❏DK Explain_____
Thyroid/ Endocrine problem	❏Yes ❏No ❏DK Explain_____
Use of alcohol	❏Yes ❏No ❏DK Explain_____
Any other significant problem	❏Yes ❏No ❏DK Explain_____

For Girls:

Has she started menstrual period?	❏Yes ❏No ❏DK When_____
Are there problems with periods?	❏Yes ❏No ❏DK Explain_____

Are you concerned about your child's physical development?	❏Yes ❏No
Are you concerned about your child's mental or emotional development?	❏Yes ❏No
Are you concerned about your child's attention span?	❏Yes ❏No

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? _____