Dr. Dianne McNeill, MD, PLLC dba Cornerstone Pediatrics

Initial History Questionnaire

Child's Full Name			_ D	ate o	f Birth	nEthnicity
Reason for today's vi	isit:					
Who may we thank f	for referring you to our	prac	ctice?			
Reason(s) for choosing	ng/changing to our prac	ctice:				
Prior Pediatrician (N	ame/City/State)					
Preferred Pharmacy:						
Allergies/Adve	erse Reactions	Yes	N	To 1	F YES	, Please list medication & reaction
Is your child allergi	c to any medications?					
Madiations		Yes	N	(a 1	IF VFS	, Please list
Wiedications		163	1 V		1 110,	, I teuse tist
Is your child on any						
(prescription & ove	· · · · · · · · · · · · · · · · · · ·					
Is your child on any						
supplements/vitam						
Specialty Care Providers		Yes	N	o 1	IF YES	, Please list
Does your child see	e any					
specialists/receive s	services such as					
PT/OT/ST, etc.?						
Prenatal/Birth	History		Nam	e of	Hospi	tal:
Delivery (circle)	Vaginal		Cesarear			C/S reason:
Gestational Age:	Term		Early:		wk	Late:wk
Birth Weight		Birth Le			gth	
Discharge Weight			Yes	No	If Ye	es, Please Comment
Any prenatal complications for mom?						
Any maternal infections? GBS?						
Maternal Medications/Antibiotics?						
Maternal Drugs/Alcohol?						
Any prenatal complications?						
Any birth complica	tions/meds for baby?					
Any problems after	birth for mom or baby	?				
Breastfeed/Pumping/Formula/Both? (circle)					Nan	ne of Formula (if any):

Has your child ever been hospitalized (ofter than birth)? Has your child had any serious injuries or accidents? Does your child had any serious medical conditions or chronic issues? ADD/ADHD Allergies Ancmia Anxiety Asthma/Reactive Airway/Wheeze (Circle) Bladder/Kidney Problems Blood Diseases/Bleeding Disorders Cancer Concussion Congenital Anomalies/Genetic Disorders Constipation Depression Developmental/Behavioral Disorders Ezezema/Atopic Dermatitis/Skin Problems Gastrointestinal Disorders/GERD Headache/Migraine Headache/Migraine Headarh/Migraine Headarh/Migrai	Past Medical History	Yes	No	0	IF YES	S, Please comment		
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Endocrine/Thyroid Problems Gastrointestinal Disorders/GERD Headache/Migraine Heart Problems/Heart Murmur Immunizations: Is your child behind? Muscle/Joint/Bone Problems or Fractures Seizures/Epilepsy Vision/Eye Problems/Glasses or Contacts? Other: Surgical History Has your child ever had surgery? Poevelopmental History Has your child met developmental milestones on time so far? Do you have any developmental concerns?	Ear or Hearing Problems							
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Immunizations: Is your child behind? Muscle/Joint/Bone Problems or Fractures Seizures/Epilepsy Vision/Eye Problems/Glasses or Contacts? Other: Surgical History Has your child ever had surgery? Personal Procedure Approx Date Physician or Hospital The Spour Child met developmental milestones on time so far? Do you have any developmental concerns?	Headache/Migraine							
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Seizures/Epilepsy Vision/Eye Problems/Glasses or Contacts? Other: Surgical History Has your child ever had surgery? Pevelopmental History Has your child met developmental milestones on time so far? Do you have any developmental concerns?	Immunizations: Is your child behind?							
Vision/Eye Problems/Glasses or Contacts? Other: Surgical History Has your child ever had surgery? Period Problems/Glasses or Contacts? Yes No IF YES, Please list Procedure/ Approx Date/ Physician or Hospital Period Problems/Glasses or Contacts? Yes No Please comment Has your child met developmental milestones on time so far? Do you have any developmental concerns?	Muscle/Joint/Bone Problems or Fractures							
Other: Surgical History Has your child ever had surgery? Pevelopmental History Has your child met developmental milestones on time so far? Do you have any developmental concerns? Yes No Please comment Please comment No Please comment No Please comment	Seizures/Epilepsy							
Other: Surgical History Has your child ever had surgery? Pevelopmental History Has your child met developmental milestones on time so far? Do you have any developmental concerns? Yes No Please comment Please comment No Please comment No Please comment	1 1 7							
Has your child ever had surgery? Hospital Developmental History Has your child met developmental milestones on time so far? Do you have any developmental concerns?	-							
Has your child ever had surgery? Hospital			N	О	IF YES	S, Please list Procedure/ Approx Date/ Physician or		
Developmental History Yes No Please comment Has your child met developmental milestones on time so far? Do you have any developmental concerns?	5				Hospit	Hospital		
Has your child met developmental milestones on time so far? Do you have any developmental concerns?								
Has your child met developmental milestones on time so far? Do you have any developmental concerns?								
Has your child met developmental milestones on time so far? Do you have any developmental concerns?	Developmental History			Yes	No	Please comment		
time so far? Do you have any developmental concerns?						<u> </u>		
	-							
Do you have any behavioral concerns?	Do you have any developmental concerns?							
	Do you have any behavioral concerns?							

Family History (Biological parents, siblings, grandparents, aunts or uncles)
M (Mother), F (Father), S (Sister), B (Brother), MGM (Maternal GrandMother), MGF (Maternal
GrandFather), PGM (Paternal GrandMother), PGF (Paternal GrandFather), MA (Maternal Aunt), PA
(Paternal Aunt), MU (Maternal Uncle), PU (Paternal Uncle)

(Paternal Aunt), MU (Maternal Uncle), PU	T .	1		
Condition	Yes	No	Relationships*	List or Comments
ADD/ADHD				
Allergies				
Anemia				
Anxiety				
Asthma/RAD/Wheeze/Chronic Bronchitis				
Bladder/Kidney Problems				
Blood Diseases/Bleeding Disorders				
Cancer				
Congenital Anomalies/Genetic Disorders				
Depression				
Developmental/Behavioral Disorders				
Diabetes				
Ear Problems/Frequent Ear Infections				
Eczema/Atopic Dermatitis				
Gastrointestinal Disorders/GERD				
-Constipation				
-Gerd/Reflux				
-Irritable Bowel Syndrome				
-Inflammatory Bowel Syndrome				
(CD/UC)				
Immune problems/Immunodeficiency				
Hearing Problems/Hearing Aid				
Heart Problems/Murmur				
-Heart Attack/Disease				
-High Blood Pressure				
-High Cholesterol				
Hypo/Hyperthyroid/Thyroid				
Muscle/Joint/Bone Problems				
Seizures/Epilepsy				
Serious Illness or Injury				
Skin Problems				
Vision/Eye Problems				
Other:				
				-

Social History									
To help us get to know you, please give us a list everyone who your child lives with:									
Mom/Guardian:									
		Social Security#:							
		oyer:Job Title:							
Phone: Email:									
Parents Relationship: Married/Divorced									
Siblings/Stepsiblings:Names/DOB:	_								
Relatives:									
Other Parents:									
Phone:En	nail:			Social Security#:					
Languages spoken in the home(s):		1	r	T					
		Yes	No	IF YES, Ple	ease Comment				
Does your child go to daycare/babysitte	er?			Where?					
Does your child go to school?				Grade:	Name of School:				
Any concerns about school performance	e?			504 or IEP	?				
Does child participate in sports?									
Does your child participate in other									
organized activities?									
How many hours per day does child sp	end			(include a	ll screens TV/com	puter/videogames)			
on media screen time?									
Does your child have TV/computer/gan	ning								
station in their room?									
Does your child have a Phone?				Phone loca	ation at night?				
				_	ctions on use?				
Does anyone smoke/vape around child?				In home?	Outside?	In car?			
Does your family have any pets?				Туре:					
Do you have smoke alarms in your home?				Carbon M	onoxide alarms?				
Does your family wear seatbelts?									
Does your child use CarSeat/BoosterSeat?				Rear Facir	ng Car Seat?				
Does your child use helmet for bike/scooter?									
Does your child use sunscreen?									
Does your child use insect repellant?									
Does anyone have gun in home?				Gun locke	ed?				
List any other current concerns:			•						
Form completed by:									
•									
Name (Printed) Name (signature)				Relationship to patient Date					