Dr. Dianne McNeill, MD, PLLC dba Cornerstone Pediatrics

Initial History Questionnaire

Child's Full Name_____________________________ Date of Birth______________Ethnicity__________________

Reason for today's visit:____

Who may we thank for referring you to our practice?____

Reason(s) for choosing/changing to our practice:____

____

Prior Pediatrician (Name/City/State)____

Preferred Pharmacy:____

Allergies/Adverse Reactions	*Yes*	*No*	*IF YES, Please list medication & reaction*
Is your child allergic to any medications?			
Medications	*Yes*	*No*	*IF YES, Please list*
Is your child on any medications? (prescription & over the counter)			
Is your child on any supplements/vitamins?			
Specialty Care Providers	*Yes*	*No*	*IF YES, Please list*
Does your child see any specialists/receive services such as PT/OT/ST, etc.?			

Prenatal/Birth History		Name of Hospital:			
Delivery (circle)	*Vaginal*	*Cesarean*		*C/S reason:*	
Gestational Age:	*Term*	*Early:_____wk*		*Late :______wk*	
Birth Weight		Birth Length			
Discharge Weight		*Yes*	*No*	*If Yes, Please Comment*	
Any prenatal complications for mom?					
Any maternal infections? GBS?					
Maternal Medications/Antibiotics?					
Maternal Drugs/Alcohol?					
Any prenatal complications?					
Any birth complications/meds for baby?					
Any problems after birth for mom or baby?					
Breastfeed/Pumping/Formula/Both? (circle)				Name of Formula (if any):	

Past Medical History	*Yes*	*No*	*IF YES, Please comment*
Has your child ever been hospitalized (other than birth)?			
Has your child had any serious injuries or accidents?			
Does your child have any serious medical conditions or chronic issues?			
ADD/ADHD			
Allergies			
Anemia			
Anxiety			
Asthma/Reactive Airway/Wheeze (Circle)			
Bladder/Kidney Problems			
Blood Diseases/Bleeding Disorders			
Cancer			
Concussion			
Congenital Anomalies/Genetic Disorders			
Constipation			
Depression			
Developmental/Behavioral Disorders			
Diabetes			
Ear or Hearing Problems			
Eczema/Atopic Dermatitis/Skin Problems			
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	Yes	No	*IF YES, Please list Procedure/ Approx Date/ Physician or Hospital*
Has your child ever had surgery?			

Developmental History	*Yes*	*No*	*Please comment*
Has your child met developmental milestones on time so far?			
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)*				
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:______________________Employer:____________________Job Title:____________________

Phone:____________________Email:_______________________Social Security#:___________________

Dad/Guardian:______________________Employer:____________________Job Title:____________________

Phone:____________________Email:_______________________Social Security#:___________________

Parents Relationship: Married/Divorced/Separated/Unmarried/It's Complicated :____________________

Siblings/Stepsiblings:Names/DOB:____

____

Relatives:____

Other Parents:________________________Employer:___________________Job Title____________________

Phone:____________________Email:_______________________Social Security#:___________________

Languages spoken in the home(s):

	Yes	*No*	*IF YES, Please Comment*
Does your child go to daycare/babysitter?			Where?
Does your child go to school?			Grade:______Name of School:
Any concerns about school performance?			504 or IEP?
Does child participate in sports?			
Does your child participate in other organized activities?			
How many hours per day does child spend on media screen time?			(include all screens … TV/computer/videogames)
Does your child have TV/computer/gaming station in their room?			
Does your child have a Phone?			Phone location at night? Any restrictions on use?
Does anyone smoke/vape around child?			In home? Outside? In car?
Does your family have any pets?			Type:
Do you have smoke alarms in your home?			Carbon Monoxide alarms?
Does your family wear seatbelts?			
Does your child use CarSeat/BoosterSeat?			Rear Facing 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 locked?

List any other current concerns:

____

Form completed by:

______________________ ______________________ ______________________ ______________________

Name (Printed) Name (signature) Relationship to patient Date