

# ROCKDALE PEDIATRICS HEALTHCARE, P.C.

## INITIAL HISTORY QUESTIONNAIRE

PATIENT NAME \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ MALE  /FEMALE

DATE OF BIRTH

FORM COMPLETED BY \_\_\_\_\_

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

DATE

### Household

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

NAME	RELATION	AGE	HEALTH PROBLEMS
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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 in the home? \_\_\_\_\_

### Birth History

Don't know the birth history

Birth weight: \_\_\_\_\_ Was the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ 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 Drink alcohol  Yes  No

Use drugs or medications  Yes  No  Used prenatal vitamins

What \_\_\_\_\_ When \_\_\_\_\_

Was the delivery  Vaginal  Cesarean If cesarean, why? \_\_\_\_\_

Was initial feeding  Formula  Breast milk How long breastfed? \_\_\_\_\_

Did baby go home with mother from the 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 any serious illnesses or medical conditions?  Yes  No  DK Explain \_\_\_\_\_

Has your child have 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 \_\_\_\_\_

Do you feel your family has enough to eat?  Yes  No  DK Explain \_\_\_\_\_

### Biological Family History DK= Don't know

Have any family members had the following:

Childhood hearing loss  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Nasal allergies  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Asthma  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Tuberculosis  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Heart Disease (before 55 years old)  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

High Cholesterol/takes cholesterol medication  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Anemia  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Bleeding disorder  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Dental Decay  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Cancer (before 55 years old)  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Liver disease  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Kidney disease  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Diabetes (before 55 years old)  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

**Biological Family History** (Continued from front side) DK= Don't know

- Bed-wetting (after 10 years old)  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Obesity  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Epilepsy or convulsions  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Alcohol abuse  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Drug abuse  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Mental illness/depression  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Immune problems, HIV, or aids  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_
- Tobacco use  Yes  No  DK Who: \_\_\_\_\_ Explain: \_\_\_\_\_

Additional family history: \_\_\_\_\_

**Past History** DK= Don't know

Does your child have or has your child ever had,

- Chickenpox  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, bronchiolitis or pneumonia  Yes  No  DK Explain \_\_\_\_\_
- Any heart problems or murmur  Yes  No  DK Explain \_\_\_\_\_
- Anemia or bleeding problem  Yes  No  DK Explain \_\_\_\_\_
- Blood transfusion  Yes  No  DK Explain \_\_\_\_\_
- HIV  Yes  No  DK Explain \_\_\_\_\_
- Organ transplant  Yes  No  DK Explain \_\_\_\_\_
- Malignancy/bone marrow transplant  Yes  No  DK Explain \_\_\_\_\_
- Chemotherapy  Yes  No  DK Explain \_\_\_\_\_
- Frequent abdominal pain  Yes  No  DK Explain \_\_\_\_\_
- Constipation requiring doctor visits  Yes  No  DK Explain \_\_\_\_\_
- Recurrent urinary tract infections and problems  Yes  No  DK Explain \_\_\_\_\_
- Congenital cataracts/retinoblastoma  Yes  No  DK Explain \_\_\_\_\_
- Metabolic/Genetic disorders  Yes  No  DK Explain \_\_\_\_\_
- Cancer  Yes  No  DK Explain \_\_\_\_\_
- Kidney disease or urologic malformations  Yes  No  DK Explain \_\_\_\_\_
- Bed-wetting (after 5 years old)  Yes  No  DK Explain \_\_\_\_\_
- Sleep problems; snoring  Yes  No  DK Explain \_\_\_\_\_
- Chronic or recurrent skin problems  Yes  No  DK Explain \_\_\_\_\_
- Frequent headaches  Yes  No  DK Explain \_\_\_\_\_
- Convulsions or other neurological problems  Yes  No  DK Explain \_\_\_\_\_
- Obesity  Yes  No  DK Explain \_\_\_\_\_
- Diabetes  Yes  No  DK Explain \_\_\_\_\_
- Thyroid or other endocrine problems  Yes  No  DK Explain \_\_\_\_\_
- High blood pressure  Yes  No  DK Explain \_\_\_\_\_
- History of serious injuries/fractures/concussions  Yes  No  DK Explain \_\_\_\_\_
- Use of alcohol or drugs  Yes  No  DK Explain \_\_\_\_\_
- Tobacco use  Yes  No  DK Explain \_\_\_\_\_
- ADHD/anxiety/mood problems/depression  Yes  No  DK Explain \_\_\_\_\_
- Developmental delays  Yes  No  DK Explain \_\_\_\_\_
- Dental decay  Yes  No  DK Explain \_\_\_\_\_
- History of family violence  Yes  No  DK Explain \_\_\_\_\_
- Sexually transmitted infections  Yes  No  DK Explain \_\_\_\_\_
- Pregnancy  Yes  No  DK Explain \_\_\_\_\_
- (For girls) Problems with her periods  Yes  No  DK Explain \_\_\_\_\_

Has had first period  Yes  No Age of first period \_\_\_\_\_

Any other significant problem \_\_\_\_\_