PEDIATRICS & NEWBORN CARE
Sunil Gupta, MD FAAP
www.PediatricsNBC.com

Initial History Questionnaire

Patient Name: _____ **DOB:** _____/_____/_____

Age: _____ ☐ **Day(s)** ☐ **Month(s)** ☐ **Year(s)** **Gender:** ☐ **Male** ☐ **Female**

Form completed by: _____ **Date completed:** _____/_____/_____

HOUSHOLD: (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 the 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 often does he/she see the parent/parents not in the home?
_____

BIRTH HISTORY

Birth Weight: _____ **(Lbs)** _____ **(Oz)** **Was the baby** ☐ **Full Term** ☐ **Early** ☐ **Late**

If early, how many weeks' gestation? _____

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

During pregnancy, did the mother smoke? ☐ **Yes** ☐ **No** **Drink alcohol?** ☐ **Yes** ☐ **No**

Use drugs or medications? ☐ **Yes** ☐ **No** **If yes, please explain** _____

Was the delivery ☐ **Vaginal** ☐ **Cesarean** **If cesarean, why?** _____

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

Was initially feeding from? ☐ **Breast** ☐ **Bottle** ☐ **Feeding Tube** ☐ **Other** _____

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 medicines or drugs?	☐ **Yes**	☐ **No**	**Explain** _____

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DEVELOPMENT

Are you concerned about your child's physical development?	☐ Yes	☐ No	**Explain** _____
Are you concerned about your child's mental/emotional 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 academic subjects? _____
Is he/she in special or resource classes? _____

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 yrs old)	☐ Yes	☐ No	**Who** _____	**Comments** _____
High Blood pressure (before 50 yrs 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 yrs old)	☐ Yes	☐ No	**Who** _____	**Comments** _____
Bed-wetting (after 10 yrs 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	**Explain** _____
(For girls) Are there any problems with her period?	☐ Yes	☐ No	**Explain** _____
Any chronic or recurrent skin problem (acne, eczema, etc)	☐ Yes	☐ No	**Explain** _____
Frequent headaches	☐ Yes	☐ No	**Explain** _____
Convulsions or other neurological 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** _____