Growing Kids Concierge
Initial History Questionnaire

Patient name:	Nickname:	
Date completed:	Patient DOB:	Patient age:
Date(s) updated:	Person filling out form:	

Social History						
Please list all those living in the child's home:				Please list other siblings not living in the home:		
Name	Relationship to child	Birth date / Age		Name	Birth date / Age	Where are they living?

Does the child live with both biological parents? Yes / No
If no, what is the current living situation?
Single-parent custody / Joint custody / Adoptive family / Foster care
How often does the child have visitation with parent(s) not living at home? _____

Birth History			
Birth Weight:	Choose one: Full-term____ Pre-term____ (_____ weeks) Post-term _____ (_____ weeks)		
Delivery: Vaginal _____ C-section _____ reason:			
Any complications during or after birth? No _____ Yes _____ Explain:			
Did baby need to go to the NICU? No _____ Yes _____ Explain:			
During pregnancy, did the mother:	Yes	No	Unknown
○ Take prenatal vitamins?			
○ Smoke or use e-cigarettes?			
○ Drink alcohol?			
○ Use marijuana or illicit drugs?			
○ Take other medications? If Yes, please list:			
Blood Type: Mother: Infant:			
Mother's lab results: ○ Hepatitis B Positive ____ Negative ____ Unknown ____ ○ HIV Positive ____ Negative ____ Unknown ____ ○ Group B Streptococcus (GBS) Positive ____ Negative ____ Unknown ____			
After birth, did the baby get: ○ Vitamin K shot? Yes ____ No ____ Unknown ____ ○ Erythromycin eye ointment? Yes ____ No____ Unknown ○ Hepatitis B shot? Yes ____ No ____ Unknown ____	How was the baby fed? ○ Bottle formula ○ Bottle breast milk ○ Breast fed		

General	Yes	No	Don't know	Explain
Do you consider your child to be in good health?				
Does your child have any special health care needs?				
Has your child ever been hospitalized?				
Is your child allergic to medicine or drugs?				

Biological Family History	Yes	No	Don't know	Who: Comments:
Childhood hearing loss				
Nasal allergies				
Asthma				

Biological Family History cont.	Yes	No	Don't know	Who: Comments:
Heart disease (before 55 years)				
High cholesterol or cholesterol medication				
Anemia				
Bleeding disorder				
Dental decay				
Cancer (before 55 years)				
Alcohol abuse				
Drug abuse				
Mental illness/depression				
Developmental disability				
Immune problems, HIV, or AIDS				
Tobacco use				
Tuberculosis				
Liver disease				
Kidney disease				
Diabetes (before 55 years)				
Bed-wetting (after 10 years)				
Obesity				
Epilepsy or convulsions				
Additional family history:				

Past Medical History	Yes	No	Don't know	Comments:
Eye problems				
Vision impairment or concerns				
Nasal allergies (dust, pets, enviro)				
Frequent ear infections				
Hearing loss or concerns				
Cavities or teeth problems				
Frequent colds or sore throats				
Asthma, wheezing				
Bronchiolitis or pneumonia				
Heart murmur or problems				
High blood pressure				
Frequent stomach pain				
Constipation				
Food allergies or intolerance				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years)				
Kidney, ureter, bladder problems				
Serious injuries or fractures				
Bone, joint or muscle problems				
Frequent headaches, dizziness				
Concussion or head injury				
Convulsions, seizures				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				

Past Medical History cont.	Yes	No	Don't know	Comments:
Thyroid or endocrine problems				
Diabetes				
Metabolic or genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				
Other medical problems:				

Surgical history			
Has your child ever had surgery? Yes _____ No _____ If yes, please provide details below.			
Surgery / Procedure	Date / Age	Where completed	Details
Other surgical / procedural problems?			

Current Medications				
Daily Medication	Dose and frequency		As Needed Medication:	Dose and Frequency

Please list all vitamins or supplements:

_____

_____

_____

Dr. Lane comments:

Dr. Lane signature: _____ Date:

_____