

Initial History Questionnaire

Name _____

ID NUMBER _____

FORM COMPLETED BY _____

DATE COMPLETED _____

BIRTH DATE _____

AGE _____

M F

Household

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, 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 birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks

Were there any prenatal or neonatal 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 your 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 had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to 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 _____ Comments _____

Nasal allergies Yes No DK Who _____ Comments _____

Asthma Yes No DK Who _____ Comments _____

Tuberculosis Yes No DK Who _____ Comments _____

Heart disease (before 55 years old) Yes No DK Who _____ Comments _____

High cholesterol/takes cholesterol medication Yes No DK Who _____ Comments _____

Anemia Yes No DK Who _____ Comments _____

Bleeding disorder Yes No DK Who _____ Comments _____

Dental decay Yes No DK Who _____ Comments _____

Cancer (before 55 years old) Yes No DK Who _____ Comments _____

(Biological Family History continued on back side.)

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

Biological Family History (Continued from front side.) DK = don't know

| | | | | | |
|----------------------------------|------------------------------|-----------------------------|-----------------------------|-----------|----------------|
| Liver disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Kidney disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Diabetes (before 55 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Bed-wetting (after 10 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Epilepsy or convulsions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Alcohol abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Drug abuse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Mental illness/depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Developmental disability | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Immune problems, HIV, or AIDS | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Tobacco use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Who _____ | Comments _____ |
| Additional family history _____ | | | | | |

Past History DK = don't know

Does your child have, or has your child ever had,

| | | | | |
|---|------------------------------|-----------------------------|-----------------------------|---------------|
| Chickenpox | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | When _____ |
| Frequent ear infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Problems with ears or hearing | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Nasal allergies | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Problems with eyes or vision | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Asthma, bronchitis, bronchiolitis, or pneumonia | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Any heart problem or heart murmur | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Anemia or bleeding problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Blood transfusion | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| HIV | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Organ transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Malignancy/bone marrow transplant | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Chemotherapy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Frequent abdominal pain | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Constipation requiring doctor visits | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Recurrent urinary tract infections and problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Congenital cataracts/retinoblastoma | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Metabolic/Genetic disorders | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Cancer | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Kidney disease or urologic malformations | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Bed-wetting (after 5 years old) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Sleep problems; snoring | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Chronic or recurrent skin problems (eg, acne, eczema) | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Frequent headaches | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Convulsions or other neurologic problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Obesity | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Diabetes | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Thyroid or other endocrine problems | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| High blood pressure | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| History of serious injuries/fractures/concussions | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Use of alcohol or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Tobacco use | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| ADHD/anxiety/mood problems/depression | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Developmental delay | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Dental decay | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| History of family violence | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Sexually transmitted infections | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Pregnancy | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| (For girls) Problems with her periods | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> DK | Explain _____ |
| Has had first period <input type="checkbox"/> Yes <input type="checkbox"/> No | Age of first period _____ | | | |
| Any other significant problem _____ | | | | |

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.*

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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