

Initial History Questionnaire

Name _____

FORM COMPLETED BY _____

DATE COMPLETED _____

ID NUMBER _____

BIRTH DATE _____

AGE _____

M _____ I _____

Home

Please list all those living in the child's home

Are there siblings not listed? If so, please list their names, ages, and where they live.

Name	Relationship to child	Birthdate	Health Problems

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 Was the delivery Vaginal Cesarean If cesarean, why? _____

Were there any prenatal or neonatal complications? _____

Yes No Explain _____

Was a NICU stay required? Yes No Explain _____

Was initial feeding Formula Breast milk How long breastfed? _____

Did your baby go home with mother from the hospital? _____

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 _____

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	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

Initial History Questionnaire (Continued from front side)

Biological Family History DK = don't know

Have any family members had the following?

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

Chickenpos	<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	<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 _____	