



INITIAL HISTORY QUESTIONNAIRE

 Name

 Person Completing Form

Male Female

 Date of Birth

 Date Form Completed

Members of Household

Name	Relationship to child	Birthdate			

Household

Please list all those living in the child's home, where they

Are there siblings not listed? If so, please list their names, ages, and

Name	Relationship to child	Birthdate	Health Problems?

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 _____

No
 During pregnancy, did mother

Use tobacco Yes No Drink alcohol Yes No

Use drugs or medications Yes No Use prenatal vitamins Yes No

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

Explain

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 _____
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 _____

Biological Family History DK = don't know

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 (eczema, acne)	<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 neurological 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 Yes No Age of first period _____

Any other significant problem(s):