Southwest Pediatrics
Initial History Questionnaire
Form completed by: _____

Child's Name: _____
Date of birth: _____
Today's Date: _____

Household:

Please list all those living in the child's home:

Name	Age	Relationship to child

This child lives with: (please check)

- □ Biological parents
- □ Adoptive parents
- □ Mother
- □ Father
- □ Joint custody
- □ Foster parent(s)
- □ Other

_____

Birth History:

Birth weight: _____
Complications with the pregnancy: _____
Complications with the birth: _____
Was the baby premature? _____
Was the delivery vaginal or cesarean? _____
During pregnancy, did the mother:
Smoke? _____
Drink alcohol? _____
Use drugs or medications? _____

Child's Health:

Does your child have any serious illnesses or medical conditions? _____
_____
Has your child ever been hospitalized? If yes, explan: _____
_____
Has your child ever had surgery? If yes, explain: _____
_____
Is your child allergic to medicine or drugs? If yes, explain: _____
_____
Does your child have any learning problems or developmental delay? If yes, explain:
_____
Are your child's immunizations up to date? □ Yes □ No □Not sure

Does your child have or ever had:

Chronic Constipation	**□ Yes**	**□ No**	**High blood pressure**	**□ Yes**	**□ No**
Problems with hearing	**□ Yes**	**□ No**	**Nasal allergies**	**□ Yes**	**□ No**
Problems with eyes or vision	**□ Yes**	**□ No**	**Frequent ear infection**	**□ Yes**	**□ No**
Heart problems	**□ Yes**	**□ No**	**Cancer**	**□ Yes**	**□ No**
Frequent abdominal pain	**□ Yes**	**□ No**	**Kidney problems**	**□ Yes**	**□ No**
Urinary tract infections	**□ Yes**	**□ No**	**Frequent headaches**	**□ Yes**	**□ No**
Skin problems	**□ Yes**	**□ No**	**Diabetes**	**□ Yes**	**□ No**
Seizures	**□ Yes**	**□ No**	**Neurologic problems**	**□ Yes**	**□ No**
Concussions	**□ Yes**	**□ No**	**ADHD**	**□ Yes**	**□ No**
History of family violence	**□ Yes**	**□ No**	**Use of alcohol/drugs**	**□ Yes**	**□ No**
Sleep problems or snoring	**□ Yes**	**□ No**	**Tobacco use**	**□ Yes**	**□ No**
Asthma	**□ Yes**	**□ No**	**Allergies**	**□ Yes**	**□ No**

Please explain any yes answers _____

Biological Family History:

Have any family members had the following? If yes, who

Nasal allergies: □ Yes □ No _____
Asthma: □ Yes □ No _____
Tuberculosis: □ Yes □ No _____
Heart disease before age 55: □ Yes □ No _____
High Cholesterol: □ Yes □ No _____
Anemia: □ Yes □ No _____
Bleeding disorder: □ Yes □ No _____
Cancer before age 55: □ Yes □ No _____
Liver disease: □ Yes □ No _____
Kidney disease: □ Yes □ No _____
Diabetes: □ Yes □ No _____
Epilepsy or seizures: □ Yes □ No _____
Alcohol abuse: □ Yes □ No _____
Drug abuse: □ Yes □ No _____
Mental illness: □ Yes □ No _____
Immune problems, HIV, or AIDs: □ Yes □ No _____
Depression: □ Yes □ No _____
Tobacco use: □ Yes □ No _____
Childhood hearing loss: □ Yes □ No _____
High blood pressure: □ Yes □ No _____

Any other significant problems? _____