

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_

DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_

AGE

M

## 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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