ROCKDALE PEDIATRICS HEALTHCARE, P.C.

INITIAL HISTORY QUESTIONAIRRE

_____ _____
PATIENT NAME FORM COMPLETED BY
____/_____/_____ MALE □ /FEMALE □ _____/_____/_____
DATE OF BIRTH DATE

Household

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

NAME	RELATION	AGE	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 the birth history

Birth weight: _____ Was the baby born at term?_____ OR ___weeks
Were there any prenatal 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 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 have any surgery? □ Yes □ No □ DK Explain _____
_____
Has your child ever been hospitalized? □ Yes □ No □ DK Explain _____
_____
Is your child allergic to any 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:_____	Explain: _____
Nasal allergies	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Asthma	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Tuberculosis	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Heart Disease (before 55 years old)	□ Yes	□ No	□ DK	Who:_____	Explain: _____
High Cholesterol/takes cholesterol medication)	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Anemia	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Bleeding disorder	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Dental Decay	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Cancer (before 55 years old)	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Liver disease	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Kidney disease	□ Yes	□ No	□ DK	Who:_____	Explain: _____
Diabetes (before 55 years old)	□ Yes	□ No	□ DK	Who:_____	Explain: _____

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

Bed-wetting (after 10 years old) ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Obesity ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Epilepsy or convulsions ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Alcohol abuse ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Drug abuse ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Mental illness/depression ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Immune problems, HIV, or aids ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Tobacco use ☐ Yes ☐ No ☐ DK Who:_____ Explain: _____
Additional family history: _____

Past History DK= Don't know

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