ALABASTER Pediatrics

INITIAL HISTORY QUESTIONNAIRE

Patients Full Name:	Birth Date
SSN:	☐ Female ☐ Male
Previous source of medical care:	
Form completed by: Relation to patient:	Date completed:

Household (please list all those living in the child's home)

Name	Relationship to child	Birth Date	Health issues	Are there parents or siblings that are not listed? If so, please list their names, ages, and locations.

Are mother and father: ☐ Married ☐ Separated ☐ Divorced

If separated or divorced, who has custody?

Does anyone other than a parent have custody? ☐ Yes ☐ No If yes, specify:

Has the family moved in the last 5 year? ☐ Yes ☐ No If yes, # of times:

Does your child attend a childcare program? ☐ Yes ☐ No

Does anyone in the house smoke? ☐ Yes ☐ No

Birth History

Pregnancy: Did the mother have any illness or problem with her pregnancy? ☐ Yes ☐ No If yes, explain:

Did the mother smoke, drink alcohol, or use drugs during the pregnancy? ☐ Yes ☐ No If yes, explain:

Delivery: ☐ Vaginal ☐ Cesarean section: If c-section, why?

Was the baby born ☐ Term ☐ Early ☐ Late
If early, how many weeks gestation?

Birth weight: Birth length:

Newborn: Did your baby have any problems right after birth? ☐ Yes ☐ No If yes, explain:

Initial feedings: ☐ Breast-feeding ☐ Formula
Any formula intolerance? ☐ Yes ☐ No

Did your baby go home with mother from the hospital? ☐ Yes ☐ No If no, explain:

Development

Do you have any concerns about your child's:		If yes, please explain:
Physical development?	☐ Yes ☐ No	
Mental or emotional development?	☐ Yes ☐ No	
Behavior at home or at school?	☐ Yes ☐ No	
Attention span?	☐ Yes ☐ No	
Academic performance?	☐ Yes ☐ No	

Past Medical History

		If yes, please explain:
Has your child ever been hospitalized?	☐ Yes ☐ No	
Has your child had any surgeries?	☐ Yes ☐ No	
Has your child had any serious injuries or accidents?	☐ Yes ☐ No	
Is your child on any daily medication?	☐ Yes ☐ No	
Is your child allergic to any medications or drugs?	☐ Yes ☐ No	
Does your child have, or has he/she ever had: :		
Recurrent ear infections (more than 3)?	☐ Yes ☐ No	
Wheezing, bronchiolitis, pneumonia, or Asthma?	☐ Yes ☐ No	
Nasal/Seasonal allergies	☐ Yes ☐ No	
Heart problems or a heart murmur?	☐ Yes ☐ No	
Anemia or a bleeding problem?	☐ Yes ☐ No	
Constipation requiring medical treatment?	☐ Yes ☐ No	
Bladder or kidney infections?	☐ Yes ☐ No	
Bed-wetting (if over 5 years old)	☐ Yes ☐ No	
Any recurrent skin problem (ex. Eczema or acne)	☐ Yes ☐ No	
Chicken pox?	☐ Yes ☐ No	
Frequent headaches?	☐ Yes ☐ No	
Seizures?	☐ Yes ☐ No	
Diabetes?	☐ Yes ☐ No	
Thyroid or other endocrine problem?	☐ Yes ☐ No	
For girls: Has she started her menstrual periods?	☐ Yes ☐ No	
Has she had any menstrual problems?	☐ Yes ☐ No	
Use of alcohol or drugs?	☐ Yes ☐ No	
Any other significant or chronic problem?	☐ Yes ☐ No	

Family History

If a family member has or has had any of the following problems, please check the box and note the family member:
M =mother F = father S = sibling GM = grandmother GF = grandfather A = Aunt U = Uncle

☐	Deafness		☐	Gastrointestinal disorder	
☐	Eye or visual problems		☐	Kidney disease	
☐	Nasal Allergies		☐	Diabetes (before 50 yrs old)	
☐	Asthma		☐	Bed-wetting (after 10 yrs old)	
☐	Eczema		☐	Thyroid or Endocrine disorder	
☐	Recurrent ear infections		☐	Epilepsy or seizures	
☐	Heart disease (before 50 yrs old)		☐	Alcohol or drug abuse	
☐	High cholesterol		☐	Mental illness	
☐	Anemia or a bleeding disorder		☐	Mental retardation	
☐	Cancer		☐	Immune problems, HIV or AIDS	
☐	Liver disease		☐	Obesity	
☐	Tuberculosis		☐	Other:	

Provider comments:

Reviewed by _____Date: _____