SOUTHWEST PEDIATRICS

Initial History Questionnaire

Patient Name _____ DOB _____ Age _____ ❑ M ❑ F

Household Information

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

Name	DOB	Relationship	Health Problems

Are there siblings not listed? If so, please list their names, ages, and where they live.

_____

_____

Birth History ■ Don't know birth history

Birth weight_____ Weeks Gestation_____

Were there any prenatal or neonatal complications? ❑Y ❑N

Explain _____

_____

During pregnancy, did mother:

Use tobacco ❑Y ❑N Drink alcohol ❑Y ❑N

Use drugs ❑Y ❑N Use medications ❑Y ❑N

What_____ When _____

Was the delivery ❑Vaginal ❑Cesarean If cesarean, why,_____

_____

_____

Was initial feeding ❑Breast milk ❑Formula

Did your baby go home with mother from the hospital?

❑Y ❑N Explain_____

_____

_____

General DK= don't know

Do you consider your child to be in good health? ❑Y ❑N ❑DK Explain _____

Does your child have any serious illnesses or medical conditions? ❑Y ❑N ❑DK Explain _____

Has your child had any surgery? ❑Y ❑N ❑DK Explain _____

Has your child ever been hospitalized? ❑Y ❑N ❑DK Explain _____

Is your child allergic to medicine or drugs? ❑Y ❑N ❑DK Explain _____

Is your child allergic to any foods? ❑Y ❑N ❑DK Explain _____

Biological Family History DK= don't know

Have any family members had the following?

Childhood hearing loss ❑Y ❑N ❑DK Who _____ Comments _____

Nasal allergies ❑Y ❑N ❑DK Who _____ Comments _____

Asthma ❑Y ❑N ❑DK Who _____ Comments _____

Tuberculosis ❑Y ❑N ❑DK Who _____ Comments _____

Heart disease (before 55 years old) ❑Y ❑N ❑DK Who _____ Comments _____

High cholesterol ❑Y ❑N ❑DK Who _____ Comments _____

Anemia ❑Y ❑N ❑DK Who _____ Comments _____

Bleeding disorder ❑Y ❑N ❑DK Who _____ Comments _____

Dental decay ❑Y ❑N ❑DK Who _____ Comments _____

Cancer (before 55 years old) ❑Y ❑N ❑DK Who _____ Comments _____

Liver disease ❑Y ❑N ❑DK Who _____ Comments _____

Biological Family History (continued from front side) DK= don't know

Kidney disease	❑Y ❑N ❑DK Who _____	Comments _____
Diabetes (before 55 years old)	❑Y ❑N ❑DK Who _____	Comments _____
Bed-wetting (after 10 years old)	❑Y ❑N ❑DK Who _____	Comments _____
Obesity	❑Y ❑N ❑DK Who _____	Comments _____
Epilepsy or convulsions	❑Y ❑N ❑DK Who _____	Comments _____
Alcohol abuse	❑Y ❑N ❑DK Who _____	Comments _____
Drug abuse	❑Y ❑N ❑DK Who _____	Comments _____
Mental illness/ depression	❑Y ❑N ❑DK Who _____	Comments _____
Developmental disability	❑Y ❑N ❑DK Who _____	Comments _____
Immune problems, HIV, or AIDS	❑Y ❑N ❑DK Who _____	Comments _____

Additional family history _____

_____

Past History DK= don't know

Does your child have, or has your child had,

Chickenpox	❑Y ❑N ❑DK When _____
Frequent ear infections	❑Y ❑N ❑DK Explain _____
Problems with ears or hearing	❑Y ❑N ❑DK Explain _____
Nasal allergies	❑Y ❑N ❑DK Explain _____
Problems with eyes or vision	❑Y ❑N ❑DK Explain _____
Asthma, bronchiolitis, or pneumonia	❑Y ❑N ❑DK Explain _____
Any heart problem or heart murmur	❑Y ❑N ❑DK Explain _____
Anemia or bleeding disorder	❑Y ❑N ❑DK Explain _____
Blood transfusion	❑Y ❑N ❑DK Explain _____
HIV	❑Y ❑N ❑DK Explain _____
Organ transplant	❑Y ❑N ❑DK Explain _____
Malignancy/ bone marrow transplant	❑Y ❑N ❑DK Explain _____
Chemotherapy	❑Y ❑N ❑DK Explain _____
Frequent abdominal pain	❑Y ❑N ❑DK Explain _____
Constipation requiring doctor visits	❑Y ❑N ❑DK Explain _____
Recurrent urinary tract infections and problems	❑Y ❑N ❑DK Explain _____
Congenital cataracts/ retinoblastoma	❑Y ❑N ❑DK Explain _____
Metabolic/ Genetic disorders	❑Y ❑N ❑DK Explain _____
Cancer	❑Y ❑N ❑DK Explain _____
Kidney disease or urologic malformations	❑Y ❑N ❑DK Explain _____
Bed-wetting (after 5 years old)	❑Y ❑N ❑DK Explain _____
Sleep problems; snoring	❑Y ❑N ❑DK Explain _____
Chronic or recurrent skin problems (acne, eczema)	❑Y ❑N ❑DK Explain _____
Frequent headaches	❑Y ❑N ❑DK Explain _____
Convulsions or other neurological problems	❑Y ❑N ❑DK Explain _____
Obesity	❑Y ❑N ❑DK Explain _____
Diabetes	❑Y ❑N ❑DK Explain _____
Thyroid or other endocrine problems	❑Y ❑N ❑DK Explain _____
High blood pressure	❑Y ❑N ❑DK Explain _____
History of serious injuries/fractures/concussions	❑Y ❑N ❑DK Explain _____
Use of alcohol or drugs	❑Y ❑N ❑DK Explain _____
Tobacco use	❑Y ❑N ❑DK Explain _____
ADHD/anxiety/mood problems/depression	❑Y ❑N ❑DK Explain _____
Developmental delay	❑Y ❑N ❑DK Explain _____
Dental decay	❑Y ❑N ❑DK Explain _____
History of family violence	❑Y ❑N ❑DK Explain _____
Sexually transmitted infections	❑Y ❑N ❑DK Explain _____
Pregnancy	❑Y ❑N ❑DK Explain _____
Problems with periods (for females)	❑Y ❑N ❑DK Explain _____

Had first period ❑ Y ❑ N Age of first period _____

Any other significant problems _____

_____