CHILDREN'S CLINIC OF WYOMISSING

INITIAL HISTORY QUESTIONAIRE

Child's Name _____ Birth Date _____ Age _____

HOUSEHOLD

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

	Name	Relationship to child	Birth Date	Health Problems
1.				
2.				
3.				
4.				
5.				
6.				
7.				

If there are siblings not listed, please list their names and ages and where they live. _____

_____

If parents are not living together or if child is not living with parents:

1. What is the child's custody status?

_____

2. How often does the child see the parent(s) not in the home?

_____

BIRTH HISTORY

Birth weight _____ Term? _____ Early? _____ Est. gestational age _____

Did the mother have any problems during delivery? _____ If yes, explain. _____

_____

Did mother use any of the following during pregnancy? Tobacco/cigarettes? _____ Alcohol? _____

Drugs or medications? _____ What? _____ When? _____

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

Did the baby have any problems after birth? _____ If yes, explain. _____

_____

Was the baby breast or bottle fed? _____

GENERAL

Do you consider your child to be in good health?	Yes	No	Explain_____
Does your child have any chronic medical conditions?	Yes	No	Explain_____
Has your child had any serious illnesses?	Yes	No	Explain_____
Has your child had any serious injuries or accidents?	Yes	No	Explain _____
Has your child had any surgery?	Yes	No	Explain _____
Has your child ever been hospitalized?	Yes	No	Explain _____
Is your child on any medications?	Yes	No	Explain _____
Does your child have any allergies to drugs or medications?	Yes	No	Explain _____

DEVELOPMENT

Are you concerned about your child's physical, mental, or emotional development?

Yes No Explain_____

Are you concerned about your child's attention span? Yes No Explain _____

How is your child's behavior in school? _____

Has he/she failed or repeated a grade in school? _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

FAMILY HISTORY

Have any family members had any of the following?

Deafness	Yes	No	Comments_____
Nasal allergies	Yes	No	Comments_____
Asthma	Yes	No	Comments_____
Tuberculosis	Yes	No	Comments_____
Heart disease (before age 50)	Yes	No	Comments_____
High blood pressure (before age 50)	Yes	No	Comments_____
High cholesterol	Yes	No	Comments_____
Anemia	Yes	No	Comments_____
Bleeding disorder	Yes	No	Comments_____
Liver disease	Yes	No	Comments_____
Kidney disease	Yes	No	Comments_____
Diabetes (before age 50)	Yes	No	Comments_____
Bed-wetting (after age 10)	Yes	No	Comments_____
Epilepsy or convulsions	Yes	No	Comments_____
Alcohol abuse	Yes	No	Comments_____
Drug abuse	Yes	No	Comments_____
Mental illness	Yes	No	Comments_____
Mental retardation	Yes	No	Comments_____
Immune problems, HIV, or AIDS	Yes	No	Comments_____

Other family history _____

PAST HISTORY

Does your child have or has he/she ever had:

Chicken pox	Yes	No	Comments_____
Frequent ear infections	Yes	No	Comments_____
Problems with ears or hearing	Yes	No	Comments_____
Nasal allergies	Yes	No	Comments_____
Problems with eyes or vision	Yes	No	Comments_____
Asthma	Yes	No	Comments_____
Bronchitis, bronchiolitis, or pneumonia	Yes	No	Comments_____
Any heart problem or heart murmur	Yes	No	Comments_____
Anemia or bleeding problem	Yes	No	Comments_____
Blood transfusion	Yes	No	Comments_____
Frequent abdominal pain	Yes	No	Comments_____
Constipation requiring doctor visits	Yes	No	Comments_____
Bladder or kidney infection	Yes	No	Comments_____
Bed-wetting (after age 5)	Yes	No	Comments_____
Any chronic or recurrent skin problem	Yes	No	Comments_____
Frequent headaches	Yes	No	Comments_____
Convulsions or other neurologic problems	Yes	No	Comments_____
Diabetes	Yes	No	Comments_____
Thyroid or endocrine problem	Yes	No	Comments_____
Use of alcohol or drugs	Yes	No	Comments_____
(For girls) Has she started her period?	Yes	No	Comments_____
(For girls) Any problems with her periods?	Yes	No	Comments_____
Any other significant problem	Yes	No	Comments_____