Pediatric Care Center of Columbiana
Initial History Questionnaire

Patient Name:_____ Birth Date:_____ Age:_____
Form Completed By:_____ Date Completed:_____

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:_____

If mother and father are not living together or if child does not live with parents, what is the child's custody status?_____

If one or both parents are not living in the home, how often does he/she see the parent(s) not in the home?_____

Birth History

Birth Weight:_____
Was the baby born at term?_____Early?_____ Late?_____
If early, how many week gestation?_____

Did mother have any illness or problems with her pregnancy?
☐ Yes ☐ No Explain_____

During pregnancy, did mother
- ☐ Smoke
- ☐ Drink alcohol
- ☐ Use drugs or medications: What?_____ When?_____

Was delivery ☐ Vaginal ☐ Cesarean
If cesarean, why?_____
Did your baby have any problems right after birth?
☐ Yes ☐ No Explain_____

Was initial feeding ☐ Breast ☐ Bottle

Did your baby go home with mother form the hospital
☐ Yes ☐ No Explain_____

General

Do you consider your child to be in good health?	☐ Yes	☐ No	Explain_____
Does your child have any serious illness or medical condition?	☐ Yes	☐ No	Explain_____
Has your child had 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 allergic to any medications or drugs?	☐ Yes	☐ No	Explain_____

Development

Are you concerned about your child's physical development?	☐ Yes	☐ No	Explain_____
Are you concerned about your child's mental/emotional development?	☐ Yes	☐ No	Explain_____
Are you concerned about your child's attention span?	☐ Yes	☐ No	Explain_____

How is his/her 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

Please check if any family members have had the following and explain below:

- ☐ Deafness
- ☐ Nasal allergies
- ☐ Asthma
- ☐ Tuberculosis
- ☐ Diabetes (before 50 years old)
- ☐ Heart disease (before 50 years old)
- ☐ High cholesterol
- ☐ Anemia
- ☐ Bleeding disorder
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Immune problems/HIV/AIDS
- ☐ Bed-wetting (after 10 years old)
- ☐ Epilepsy/convulsions
- ☐ Alcohol abuse
- ☐ Drug abuse
- ☐ Mental illness
- ☐ Mental retardation

Explanations or additional family history: _____

Past History

- ☐ Chickenpox
- ☐ Frequent ear infections
- ☐ Problem with ears/hearing
- ☐ Nasal allergies
- ☐ Problem with eyes/vision
- ☐ Asthma/bronchitis/bronchiolitis/pneumonia
- ☐ Heart problem/murmur
- ☐ Blood transfusion
- ☐ Frequent abdominal pain
- ☐ Constipation requiring doctor visit
- ☐ Bladder/kidney infection
- ☐ Bed-wetting (after 5 years old)
- ☐ Skin problems (acne, eczema)
- ☐ Anemia or bleeding problem
- ☐ Frequent headaches
- ☐ Convulsions or neurologic problems
- ☐ Diabetes
- ☐ Thyroid or endocrine problem
- ☐ Girls: Started menstrual period
- ☐ Girls: Problem with periods
- ☐ Alcohol/drug use

Explanations or additional medical history: _____