Bulloch Pediatrics Group LLC
Initial History Questionnaire

Today's Date: _____

Patient Name: _____ DOB: _____ Age: _____ Form Completed By: _____

HOUSEHOLD

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

Child's Name	DOB	Health Problems
Child's Name	DOB	Health Problems
Child's Name	DOB	Health Problems

Are there any siblings not listed? If so, please list 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 parent/parents not in the home? _____

Does anyone smoke in the home?

☐ Yes Whom? _____ ☐ No

BIRTH HISTORY

Birth Weight _____

Was the baby born **at term, early** or **late**?(Circle one)

If early, how many weeks gestation? _____

Did the mother have any illness or problem with pregnancy?

☐Yes ☐No Explain: _____

During pregnancy, did mother:

Smoke ☐Yes ☐No Drink Alcohol ☐Yes ☐No

Use drugs or medications ☐Yes ☐No

What: _____ When: _____

Was the 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 from the hospital?

☐Yes ☐No Explain:

_____

GENERAL

Is you child up to date on immunizations?	☐Yes ☐No Explain _____
Do you consider you 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 you child ever been hospitalized?	☐Yes ☐No Explain _____
Is your child allergic to any medicine or drugs?	☐Yes ☐No Explain _____

PAST HISTORY

Chicken Pox	☐Yes ☐No	Who _____	Explain _____
Frequent ear infections	☐Yes ☐No	Who _____	Explain _____
Problems with ears or hearing	☐Yes ☐No	Who _____	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐Yes ☐No	Who _____	Explain _____
Heart problem or heart murmur	☐Yes ☐No	Who _____	Explain _____
Anemia or bleeding problem	☐Yes ☐No	Who _____	Explain _____
Blood transfusion	☐Yes ☐No	Who _____	Explain _____
Frequent abdominal pain	☐Yes ☐No	Who _____	Explain _____
Constipation requiring doctors visits	☐Yes ☐No	Who _____	Explain _____
Bladder or kidney infection	☐Yes ☐No	Who _____	Explain _____
Bed-wetting (after 5 years old)	☐Yes ☐No	Who _____	Explain _____
(For girls) Has she started her menstrual periods?	☐Yes ☐No	Who _____	Explain _____
(For girls) Are there problems with her period?	☐Yes ☐No	Who _____	Explain _____
Chronic or recurrent skin problems (acne, eczema, etc.)	☐Yes ☐No	Who _____	Explain _____
Frequent headaches	☐Yes ☐No	Who _____	Explain _____
Convulsions or other neurological problem	☐Yes ☐No	Who _____	Explain _____
Diabetes	☐Yes ☐No	Who _____	Explain _____
Thyroid or other endocrine problem	☐Yes ☐No	Who _____	Explain _____
Any other significant problem	☐Yes ☐No	Who _____	Explain _____
Use of alcohol or drugs	☐Yes ☐No	Who _____	Explain _____
Persistent cough in excess of 3 weeks	☐Yes ☐No	Who _____	Explain _____
Bloody Sputum	☐Yes ☐No	Who _____	Explain _____
Night Sweats	☐Yes ☐No	Who _____	Explain _____
Weight loss	☐Yes ☐No	Who _____	Explain _____
Anorexia	☐Yes ☐No	Who _____	Explain _____
Recurrent fever with no known source	☐Yes ☐No	Who _____	Explain _____

DEVELOPMENT

Are you concerned about your child's physical development? ☐Yes ☐No Explain _____
Are you concerned about your child's mental or emotional development? ☐Yes ☐No Explain _____
Are you concerned about your child's attention span? ☐Yes ☐No Explain _____

FAMILY HISTORY

Have any family members had any of the following:

Deafness ☐Yes ☐No Who _____ Explain _____
Nasal Allergies ☐Yes ☐No Who _____ Explain _____
Asthma ☐Yes ☐No Who _____ Explain _____
Tuberculosis ☐Yes ☐No Who _____ Explain _____
Heart Disease (before 50 yrs old) ☐Yes ☐No Who _____ Explain _____
High Blood Pressure (before 50) ☐Yes ☐No Who _____ Explain _____
High Cholesterol ☐Yes ☐No Who _____ Explain _____
Anemia ☐Yes ☐No Who _____ Explain _____
Bleeding Disorder ☐Yes ☐No Who _____ Explain _____
Liver Disease ☐Yes ☐No Who _____ Explain _____
Kidney Disease ☐Yes ☐No Who _____ Explain _____
Diabetes (before 50) ☐Yes ☐No Who _____ Explain _____
Bed Wetting (after 10 yrs old) ☐Yes ☐No Who _____ Explain _____
Epilepsy or Convulsions ☐Yes ☐No Who _____ Explain _____
Alcohol Abuse ☐Yes ☐No Who _____ Explain _____
Drug Abuse ☐Yes ☐No Who _____ Explain _____
Mental Illness ☐Yes ☐No Who _____ Explain _____
Mental Retardation ☐Yes ☐No Who _____ Explain _____
Immune problems, HIV, or AIDS ☐Yes ☐No Who _____ Explain _____

Any additional family history:

_____
_____
_____
_____
_____