

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.

parents,
Child Name DOB Health Problems

Child Name DOB Health Problems
home? _____

Child Name DOB Health Problems

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

If mother and father are not living together or if child does not live with

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

Does anyone smoke in the home? Yes Whom? _____ No

BIRTH HISTORY

Birth Weight _____
Was the baby born at term? _____ Early? _____ Late?
If early, how many weeks' gestation? _____

Did mother have any illness or problem with pregnancy?
 Yes No Explain: _____

During pregnancy, did mother:
Smoke Yes No Drink Alcohol Yes No
Explain: _____

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 you baby go home with mother from the hospital?

Yes No

GENERAL

Is your child up to date on immunizations? Yes No Explain _____

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 medicine 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 or emotional development? Yes No Explain

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

If your child is in school:

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 a special or resource classes? _____

FAMILY HISTORY

Have any family members had any of the following:

Deafness Yes No Who _____ Comments

Nasal Allergies Yes No Who _____ Comments

Asthma Yes No Who _____ Comments

Tuberculosis Yes No Who _____ Comments

Heart Disease (before 50 yrs old) Yes No Who _____ Comments

High Blood Pressure (before 50 yrs old) Yes No Who _____ Comments

High Cholesterol Yes No Who _____ Comments

Anemia Yes No Who _____ Comments

Bleeding disorder Yes No Who _____ Comments

Liver disease Yes No Who _____ Comments

Kidney disease Yes No Who _____ Comments

Diabetes (before 50 yrs old) Yes No Who _____ Comments

Bed Wetting (After 10 yrs old) Yes No Who _____ Comments

Epilepsy or convulsions Yes No Who _____ Comments

Alcohol abuse Yes No Who _____ Comments

Drug abuse Yes No Who _____ Comments _____

Mental illness Yes No Who _____ Comments _____

Mental retardation Yes No Who _____ Comments _____

Immune problems, HIV, or AIDS Yes No Who _____ Comments _____

Additional family history _____

PAST HISTORY

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

Chickenpox 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 doctor visits Yes No Who _____ Explain _____

Bladder or kidney infection Yes No Who _____ Explain _____

Bed-wetting (after 5 yrs 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 problem (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
Who_____ Explain_____

Yes No

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