

**CHILDREN'S CLINIC OF WYOMISSING
INITIAL HISTORY QUESTIONNAIRE**

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 medicines? 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:

Chickenpox	() 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 _____
