


EAST LAKE PEDIATRICS INITIAL HISTORY QUESTIONNAIRE

 <p>FORM COMPLETED BY _____ DATE COMPLETED _____</p>	NAME _____ ID NUMBER _____ BIRTHDATE _____ AGE _____ <input type="radio"/> M <input type="radio"/> F
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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 AND 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/PARENTS NOT IN THE HOME?

BIRTH HISTORY

BIRTH WEIGHT _____ WAS THE BABY BORN AT TERM? ___ EARLY? <input type="radio"/> LATE? <input type="radio"/> IF EARLY, HOW MANY WEEKS GESTATION? _____ DID MOTHER HAVE ANY ILLNESS OR PROBLEM WITH PREGNANCY? <input type="radio"/> YES <input type="radio"/> NO EXPLAIN _____	WAS THE DELIVERY <input type="radio"/> VAGINAL? <input type="radio"/> CESAREAN? IF CESAREAN, WHY? _____ DID YOUR BABY HAVE ANY PROBLEMS RIGHT AFTER BIRTH? <input type="radio"/> YES <input type="radio"/> NO EXPLAIN _____
DURING PREGNANCY DID MOTHER: SMOKE? <input type="radio"/> YES <input type="radio"/> NO DRINK ALCOHOL? <input type="radio"/> YES <input type="radio"/> NO USE DRUGS OR MEDICATION? <input type="radio"/> YES <input type="radio"/> NO WHAT? _____ WHEN? _____	WAS INITIAL FEEDING <input type="radio"/> BREAST? <input type="radio"/> BOTTLE? DID YOUR BABY GO HOME WITH MOTHER FROM THE HOSPITAL? <input type="radio"/> YES <input type="radio"/> NO EXPLAIN _____

GENERAL

QUESTION	YES	NO	COMMENTS
DO YOU CONSIDER YOUR CHILD TO BE IN GOOD HEALTH?			
DOES YOUR CHILD HAVE ANY SERIOUS ILLNESS OR MEDICAL CONDITION?			
HAS YOUR CHILD HAD SERIOUS INJURIES OR ACCIDENTS?			
HAS YOUR CHILD HAD ANY SURGERY?			
HAS YOUR CHILD EVER BEEN HOSPITALIZED?			
IS YOUR CHILD ALLERGIC TO ANY MEDICINES OR DRUGS?			

DEVELOPMENT

QUESTION	YES	NO	COMMENTS
ARE YOU CONCERNED ABOUT YOUR CHILD'S PHYSICAL DEVELOPMENT?			
ARE YOU CONCERNED ABOUT YOUR CHILD'S MENTAL OR EMOTIONAL DEVELOPMENT?			
ARE YOU CONCERNED ABOUT YOUR CHILD'S ATTENTION SPAN?			
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. Have Any Family Members Had the Following:
INITIAL HISTORY QUESTIONNAIRE, PAGE 2 OF 2

DEAFNESS	YES	NO	WHO?	COMMENTS
NASAL ALLERGIES	YES	NO	WHO?	COMMENTS
ASTHMA	YES	NO	WHO?	COMMENTS
TUBERCULOSIS	YES	NO	WHO?	COMMENTS
HEART DISEASE BEFORE AGE 50	YES	NO	WHO?	COMMENTS
HIGH BLOOD PRESSURE BEFORE AGE 50	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 AGE 50	YES	NO	WHO?	COMMENTS
BED-WETTING AFTER 10 YEARS OF AGE	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
ADD'L FAMILY HISTORY				

PAST HISTORY. Does Your Child Have, or Has He/She Ever Had the Following:

CHICKENPOX	YES	NO	WHEN?
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, 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 5 YEARS OF AGE	YES	NO	COMMENTS
(FOR GIRLS) HAS SHE STARTED HER MENSTRUAL PERIODS?	YES	NO	COMMENTS
(FOR GIRLS) ARE THERE PROBLEMS WITH HER PERIODS?	YES	NO	COMMENTS
ANY CHRONIC OR RECURRENT SKIN PROBLEM (ACNE, ECZEMA, ETC.)?	YES	NO	COMMENTS
FREQUENT HEADACHES	YES	NO	COMMENTS
CONVULSIONS OR OTHER NEUROLOGIC PROBLEM	YES	NO	COMMENTS
DIABETES	YES	NO	COMMENTS
THYROID OR OTHER ENDOCRINE PROBLEM	YES	NO	COMMENTS
ANY OTHER SIGNIFICANT PROBLEM	YES	NO	COMMENTS
USE OF ALCOHOL OR DRUGS	YES	NO	COMMENTS