

DU PAGE PEDIATRICS, LTD.
INITIAL HISTORY QUESTIONNAIRE

Date _____

CHILD'S NAME _____ BIRTH DATE _____

FATHER'S NAME _____ MOTHER'S NAME _____

ADDRESS _____

HOME PHONE _____ WORK PHONE (FATHER) _____ EMPLOYER(FATHER) _____

WORK PHONE(MOTHER) _____ EMPLOYER(MOTHER) _____ CELL PHONE _____

PARENTS MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER _____

ANY FORMER MARRIAGES? FATHER YES NO MOTHER YES NO

REFERRED BY _____

HOUSEHOLD

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

<u>NAME</u>	<u>RELATIONSHIP TO CHILD</u>	<u>AGE</u>	<u>HEALTH PROBLEMS</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Have any of your children died? _____

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 _____ Apgar Scores _____ Was the delivery Vaginal? Cesarean? If cesarean, why? _____

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

Did your baby have any problems right after birth? Yes No Explain _____

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

Was initial feeding Breast? Bottle? Did your baby go home with mother from the hospital? Yes No Explain _____

During pregnancy, did mother Smoke? Yes No Drink alcohol? Yes No Use drugs or medications? Yes No What _____ When _____

GENERAL

Are you concerned about your child's 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 medicines or drugs? Yes No Explain _____

In times of stress, do you have support available? 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:

Are you concerned about his/her behavior in school? Yes No Explain _____

Has he/she failed or repeated a grade in school? Yes No Explain _____

Are you concerned about how he/she is doing in academic subjects? Yes No Explain _____

Is he/she in special or resource classes? Yes No Explain _____

Does he/she have problems getting along well with other children? Yes No Explain _____

(OVER →)

FAMILY HISTORY

Have any family members had the following?:

(including parents, grandparents, aunts, uncles and cousins)

Deafness	Yes	No	Who	Comments
Nasal allergies or food allergies	Yes	No	Who	Comments
Asthma	Yes	No	Who	Comments
Tuberculosis	Yes	No	Who	Comments
Heart disease (before 50 years old)	Yes	No	Who	Comments
High blood pressure (before 50 years 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 years old)	Yes	No	Who	Comments
Bed-wetting (after 10 years 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
Cancer	Yes	No	Who	Comments
Additional family history _____				

PAST HISTORY

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

Chickenpox	Yes	No	When
Frequent ear infections	Yes	No	Explain
Problems with ears or hearing	Yes	No	Explain
Nasal allergies or food allergies	Yes	No	Explain
Problems with eyes or vision	Yes	No	Explain
Asthma, bronchitis, bronchiolitis, or pneumonia	Yes	No	Explain
Any heart problem or heart murmur	Yes	No	Explain
Anemia or bleeding problem	Yes	No	Explain
Blood transfusion	Yes	No	Explain
Frequent abdominal pain	Yes	No	Explain
Constipation requiring doctor visits	Yes	No	Explain
Bladder or kidney infection	Yes	No	Explain
Bed-wetting (after 6 years old)	Yes	No	Explain
(For girls) Has she started her menstrual periods?	Yes	No	When
(For girls) Are there problems with her periods?	Yes	No	Explain
Any chronic or recurrent skin problem (acne, eczema, etc.)	Yes	No	Explain
Frequent headaches	Yes	No	Explain
Convulsions or other neurological problem	Yes	No	Explain
Diabetes	Yes	No	Explain
Thyroid or other endocrine problem	Yes	No	Explain
Any other significant problem	Yes	No	Explain
Use of alcohol or drugs	Yes	No	Explain