DU PAGE PEDIATRICS, LTD.
INITIAL HISTORY QUESTIONNAIRE **Date**_____

CHILD'S NAME: _____ BIRTH DATE: _____ HOME PHONE_____

FATHER'S NAME_____ MOTHER'S NAME_____

ADDRESS: _____

WORK PHONE (FATHER):_____ CELL# (FATHER)_____ EMPLOYER(FATHER)_____

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

PARENTS MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER _____

ANY FORMER MARRIAGES? FATHER- YES NO MOTHER- YES NO

REFERRED BY_____ E-MAIL_____

HOUSEHOLD

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

NAME	RELATIONSHIP TO CHILD	AGE	HEALTH PROBLEMS

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

Do you have specific concerns 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_____

CHILD'S NAME: _____BIRTH DATE: _____

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_____
Intellectual/Developmental Disability	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_____