DU PAGE PEDIATRICS, LTD.
UPDATED HISTORY QUESTIONNAIRE **Date** ____________________

CHILD'S NAME____________________ BIRTH DATE____________________ HOME PHONE____________________

ADDRESS____________________ CITY____________________ STATE________ ZIP CODE ____________

WORK PHONE (FATHER)____________________ CELL # (FATHER)____________________ EMPLOYER (FATHER)____________________

WORK PHONE (MOTHER) ____________________ CELL # (MOTHER)____________________ EMPLOYER (MOTHER)____________________

PARENTS MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER ____________________

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?____________________

GENERAL

Do you have any 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____________________

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____________________
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	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____