

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

Date \_\_\_\_\_

CHILD'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_ HOME PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

NAME OF PARENT/GUARDIAN #1 \_\_\_\_\_

NAME OF PARENT/GUARDIAN #2 \_\_\_\_\_

WORK PHONE # (PARENT/GUARDIAN #1) \_\_\_\_\_ CELL# (PARENT/GUARDIAN #1) \_\_\_\_\_

EMPLOYER (PARENT/GUARDIAN #1) \_\_\_\_\_

WORK PHONE # (PARENT/GUARDIAN #2) \_\_\_\_\_ CELL# (PARENT/GUARDIAN #2) \_\_\_\_\_

EMPLOYER (PARENT/GUARDIAN #2) \_\_\_\_\_

PARENTS' MARITAL STATUS: SINGLE MARRIED WIDOWED DIVORCED SEPARATED OTHER \_\_\_\_\_

ANY FORMER MARRIAGES? PARENT/GUARDIAN #1: YES NO PARENT/GUARDIAN #2: YES NO

HOW DID YOU FIND OUT ABOUT US? \_\_\_\_\_ E-MAIL \_\_\_\_\_

**HOUSEHOLD**

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

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

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 parents 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 \_\_\_\_\_  
At any point during the pregnancy, was your baby breech? Yes No  
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)

	Yes	No	Who	Comments
Deafness			_____	_____
Nasal allergies or food allergies			_____	_____
Asthma			_____	_____
Tuberculosis			_____	_____
Heart disease (before 50 years old)			_____	_____
High blood pressure (before 50 years old)			_____	_____
High cholesterol			_____	_____
Anemia			_____	_____
Bleeding disorder			_____	_____
Liver disease			_____	_____
Kidney disease			_____	_____
Diabetes (before 50 years old)			_____	_____
Bed-wetting (after 10 years old)			_____	_____
Epilepsy or convulsions			_____	_____
Alcohol abuse			_____	_____
Drug abuse			_____	_____
Mental illness			_____	_____
Intellectual/Developmental Disability			_____	_____
Immune problems, HIV or AIDS			_____	_____
Cancer			_____	_____
Additional family history			_____	_____
			_____	_____
			_____	_____
			_____	_____
			_____	_____

**PAST HISTORY**

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

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