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

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 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____

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)

Condition	Yes	No	Who	Comments
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____

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PAST HISTORY

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

Condition	Yes	No	Details
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____