DU PAGE PEDIATRICS, LTD.
UPDATED 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 ______________

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.______________________________
____
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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?______________

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____

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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____