



# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

FORM COMPLETED BY \_\_\_\_\_ DATE COMPLETED \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_  
M F

## Household

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

Name	Relationship to child	Birth date	Health problems

Are there siblings not listed? If so, please list their names, ages, and where they live. \_\_\_\_\_

What is the child's living situation if not with both biological parents?

- Lives with adoptive parents
- Joint custody
- Single custody
- Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?  
\_\_\_\_\_

## Birth History Don't know birth history

Birth weight \_\_\_\_\_ Wash the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ weeks

Were there any prenatal or neonatal complications?

Yes  No Explain \_\_\_\_\_

Was the delivery  Vaginal  Cesarean If cesarean, why?

\_\_\_\_\_  
\_\_\_\_\_

Was a NICU stay required?  Yes  No Explain \_\_\_\_\_

Was initial feeding  Formula  Breast milk How long breastfed?

Did your baby go home with mother from the hospital?  
 Yes  No Explain \_\_\_\_\_  
\_\_\_\_\_

During pregnancy, did mother

Use tobacco  Yes  No Drink alcohol  Yes  No

Use drugs or medications  Yes  No  Used prenatal vitamins

What \_\_\_\_\_ When \_\_\_\_\_

## General DK = don't know

Do you consider your child to be in good health?  Yes  No  DK Explain \_\_\_\_\_

Does your child have any serious illnesses or medical conditions?  Yes  No  DK Explain \_\_\_\_\_

Has your child had any surgery?  Yes  No  DK Explain \_\_\_\_\_

Has your child ever been hospitalized  Yes  No  DK Explain \_\_\_\_\_

Is your child allergic to medicine or drugs?  Yes  No  DK Explain \_\_\_\_\_

Do you feel your family has enough to eat?  Yes  No  DK Explain \_\_\_\_\_

## Biological Family History DK = don't know

Have any family members had the following?

- Childhood hearing loss  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Nasal allergies  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Asthma  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Tuberculosis  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Heart disease (before 55 years old)  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- High cholesterol/takes cholesterol medication  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Anemia  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Bleeding disorder  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Dental decay  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_
- Cancer (before 55 years old)  Yes  No  DK Who \_\_\_\_\_ Comments \_\_\_\_\_

(Biological Family History continued on back side.)



**Biological Family History** (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

**Past History** DK = don't know

Does your child have, or has your child ever had,	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems: snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tabacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problem with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Age of first period _____	
Any other significant problem _____				