|  |                  |                |            | _                   |  |                                       |  |  |
|--|------------------|----------------|------------|---------------------|--|---------------------------------------|--|--|
| Initial History Qu                         | estionna         | ire            |            | Name                |  |                                       |  |  |
| , , , , , , , , , , , , , , , , , , ,      |                  |                |            | ID NUMBER           |  |                                       |  |  |
|  |                  |                |            |                     |  |                                       |  |  |
| FORM COMPLETED BY                          | COMPLETED        |                | BIRTH DATE |                     |  |                                       |  |  |
| Hamakald                                   |                  |                |            |                     |  | M F                                   |  |  |
| Household                                  |                  |                |            |                     |  |                                       |  |  |
| Please list all those living in the child' |                  |                |            | •                   | e list their names, ages, and where                          |                                       |  |  |
| Relationship                               |                  | Health         |            | they live           |  |                                       |  |  |
| Name to child                              | date             | problems       |            |                     |  |                                       |  |  |
|  |                  |                |            |                     | •  | with both biological parents?         |  |  |
|  |                  |                |            |                     |  | custody   Single custody              |  |  |
|  |                  |                |            | Lives with fos      | •  |                                       |  |  |
|  |                  |                |            |                     |  | he home, how often does the child see |  |  |
|  |                  |                |            | the parent(s) no    | t in the home?   |                                       |  |  |
|  |                  |                |            |                     |  |                                       |  |  |
| Divide History                             |                  |                |            |                     |  |                                       |  |  |
| Birth History ■ Don't kn                   |                  |                |            |                     |  |                                       |  |  |
| Birth weightWas the baby                   |                  |                | we         | eks Was the deliver | y 🗌 Vaginal 🗌 Cesar  | rean If cesarean, why?                |  |  |
| Were there any prenatal or neonatal        |                  |                |            |                     |  |                                       |  |  |
| ☐ Yes ☐ No Explain                         |                  |                |            |                     |  |                                       |  |  |
|  |                  |                |            | <del>-</del> -      |  |                                       |  |  |
| Was a NICU stay required? ☐ Yes            | ; ∐ No Exp       | lain           |            |                     | Was initial feeding  Formula Breast milk How long breastfed? |                                       |  |  |
|  |                  |                |            |                     | o home with mother fro                                       | ·                                     |  |  |
| During pregnancy, did mother               | 5                |                |            | ⊔ Yes ⊔ No          | Explain  |                                       |  |  |
| Use tobacco   Yes  No                      |                  | hol 🗆 Yes      |            |                     |  |                                       |  |  |
| Use drugs or medications                   |                  |                |            |                     |  |                                       |  |  |
|  | vvnen            |                |            |                     |  |                                       |  |  |
| 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 illn      | nesses or medica | al conditions? | □Yes       | □ No □ DK Explain   | 1  |                                       |  |  |
|  |                  |                |            |                     |  |                                       |  |  |
| Has your child had any surgery? $\Box$     | Yes 🗆 No [       | □ DK Expla     | in         |                     |  |                                       |  |  |
| Has your child ever been hospitalized      | <br>d? □ Yes □   | No □ DK        | Explain    |                     |  |                                       |  |  |
|  |                  |                |            |                     |  |                                       |  |  |
| Is your child allergic to medicine or      | drugs? 🗌 Yes     | □ No □ [       | OK Expla   | in                  |  |                                       |  |  |
| De veu feel veur femily has eneugh f       |                  |                | DK Eval    | : <u></u>           |  |                                       |  |  |
| Do you feel your family has enough to      |                  |                | ок Ехріг   | ıın                 |  |                                       |  |  |
| Biological Family Histo                    |                  | on't know      |            |                     |  |                                       |  |  |
| Have any family members had the fo         | •                |                |            | 14.0                |  |                                       |  |  |
| Childhood hearing loss                     |                  | Yes 🗆 No       |            | Who                 |  | nts                                   |  |  |
| Nasal allergies                            |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| Asthma                                     |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| Tuberculosis                               |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| Heart disease (before 55 years old)        |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| High cholesterol/takes cholesterol m       |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| Anemia                                     |                  | Yes 🗆 No       | □ DK       | Who                 |  | nts                                   |  |  |
| Bleeding disorder                          |                  | Yes □ No       | □ DK       | Who                 |  | nts                                   |  |  |
| Dental decay                               | 1.1              | Yes □ No       | □ DK       | Who                 | Comme  | NES                                   |  |  |

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Cancer (before 55 years old)



☐ Yes ☐ No ☐ DK Who

(Biological Family History continued on back side.)

Comments

| Biological Family History   | (Continued from | n front side | .) DK        | = don' | t know       |          |          |
|---|-----------------|--------------|--------------|--------|--------------|----------|----------|
| Liver disease   | ☐ Yes           | □ No         | □ DK         | Who    |              |          | Comments |
| Kidney disease  | ☐ Yes           | □No          | □DK          |        |              |          |          |
| Diabetes (before 55 years old)  | ☐ Yes           | □No          | □ DK         |        |              |          |          |
| Bed-wetting (after 10 years old)                                      | ☐ Yes           | □No          | □ DK         |        |              |          |          |
| Obesity   | ☐ Yes           | □No          | _ DK         |        |              |          |          |
| Epilepsy or convulsions   | ☐ Yes           | □No          | □ DK         |        |              |          |          |
| Alcohol abuse   | ☐ Yes           | □No          | □ DK         | Who    |              |          | Comments |
| Drug abuse  | ☐ Yes           | □No          | □DK          |        |              |          |          |
| Mental illness/depression   | ☐ Yes           | □No          | □ DK         | Who    |              |          | Comments |
| Developmental disability  | ☐ Yes           | □No          | $\square$ DK | Who    |              |          | Comments |
| Immune problems, HIV, or AIDS   | ☐ Yes           | □No          | $\square$ DK | Who    |              |          | Comments |
| Tobacco use   | ☐ Yes           | □No          | $\square$ DK | Who    |              |          | Comments |
| Additional family history   |                 |              |              |        |              |          |          |
|   |                 |              |              |        |              |          |          |
| Past History DK = don't know  |                 |              |              |        |              |          |          |
| Does your child have, or has your child eve                           | r had,          |              |              |        |              |          |          |
| Chickenpox  | •               | □Y           | es 🗆         | No     | □DK          | When     |          |
| Frequent ear infections   |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Problems with ears or hearing   |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Nasal allergies   |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Problems with eyes or vision  |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Asthma, bronchitis, bronchiolitis, or pneumo                          | onia            | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Any heart problem or heart murmur                                     |                 | □Y           | es 🗆         | No     | $\square$ DK | Explain  |          |
| Anemia or bleeding problem  |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Blood transfusion   |                 | □Y           | es 🗆         | No     | $\square$ DK | Explain  |          |
| HIV   |                 | □Y           | es 🗆         | No     | $\square$ DK | Explain  |          |
| Organ transplant  |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Malignancy/bone marrow transplant                                     |                 | □Y           | es 🗆         | No     | $\square$ DK | Explain  |          |
| Chemotherapy  |                 | □Y           | es 🗆         | No     | $\square$ DK | Explain  |          |
| Frequent abdominal pain   |                 | □Y           | es 🗆         | No     | □ DK         | Explain  |          |
| Constipation requiring doctor visits                                  |                 | □Y           | es 🗆         | No     | $\square$ DK | •        |          |
| Recurrent urinary tract infections and probl                          | ems             | □Y           | es 🗆         | No     | □ DK         | -        |          |
| Congenital cataracts/retinoblastoma                                   |                 | □Y           |              |        | □ DK         | Explain  |          |
| Metabolic/Genetic disorders   |                 | □Y           |              |        | □ DK         | Explain  |          |
| Cancer  |                 | □ Y          |              |        | □ DK         |          |          |
| Kidney disease or urologic malformations                              |                 | □ Y          |              |        | □ DK         |          |          |
| Bed-wetting (after 5 years old)                                       |                 | □ Y          |              |        | □ DK         | Explain  |          |
| Sleep problems; snoring   | ,               | □Y           |              |        | □ DK         |          |          |
| Chronic or recurrent skin problems (eg, acr                           | ne, eczema)     |              |              |        | □ DK         |          |          |
| Frequent headaches  |                 |              |              |        | □ DK         |          |          |
| Convulsions or other neurologic problems                              |                 | □ Y          |              |        | □ DK         |          |          |
| Obesity   |                 | □ Y          |              |        | □ DK         | •        |          |
| Diabetes  |                 | □Y           |              |        | □ DK         |          |          |
| Thyroid or other endocrine problems                                   |                 | □Y           |              |        |              |          |          |
| High blood pressure   |                 | □ Y          |              |        | □ DK         | '        |          |
| History of serious injuries/fractures/concuss Use of alcohol or drugs | ions            | □ Y<br>□ Y   |              |        |              |          |          |
| Tobacco use   |                 | □Y           |              |        |              |          |          |
|   |                 | _            |              |        |              | •        |          |
| ADHD/anxiety/mood problems/depression                                 |                 | □ Y<br>□ Y   |              |        |              |          |          |
| Developmental delay  Dental decay                                     |                 | ⊔ ĭ<br>□ Y   |              |        | □ DK         |          |          |
| History of family violence  |                 | □ Y          |              |        | □ DK         | •        |          |
| Sexually transmitted infections                                       |                 | □Y           |              |        | □ DK         |          |          |
| Pregnancy   |                 | □Y           |              |        | □ DK         |          |          |
| (For girls) Problems with her periods                                 |                 | □Y           |              |        | □ DK         | •        |          |
| Has had first period Yes No A   | use of first po |              |              |        |              | -^hiaiii |          |
| Any other significant problem   | or in ac per    | .54          |              | _      |              |          |          |

This American Academy of Pediatrics Initial History Questionnaire is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition.

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