INITIAL HISTORY QUESTIONNAIRE

Ballard Pediatric Clinic
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FORM COMPLETED BY _____ DATE COMPLETED _____

Patient Name _____ M / F

Date of Birth _____

Household

Please list all individuals living in the child's home:

Name	Relationship to child	Birthdate	Biological Parent Y / N	Adoptive Parent Y / N	Foster Parent Y / N	Other

If divorced: ❑ Joint Custody ❑ Single Custody

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

Are there siblings not listed? Y / N If so, please list their names, ages and where they live: _____

Biological Family History DK = don't know

Have any biological family members had the following?				**Who, in relation to the patient?**	
Childhood hearing loss	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Nasal allergies/Hay fever	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Asthma	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Tuberculosis	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Heart disease (before 55 years male/65 female)	❑ 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/significant cavities	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Cancer (before 55 years old)	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Liver Disease	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Kidney Disease	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Diabetes (before 55 years old)	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Bedwetting (after 7 years old)	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Obesity	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Epilepsy or convulsions	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Alcohol abuse	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Drug abuse	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Mental illness/depression	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Developmental disability/autism	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Tobacco use	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Learning disability	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
ADHD	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Lazy eye/strabismus	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Hip dysplasia	❑ Yes	❑ No	❑ DK	Who _____	Comments _____
Hypertension/High blood pressure	❑ Yes	❑ No	❑ DK	Who _____	Comments _____

Additional family history _____

OFFICE USE ONLY:
Provider review: _____
Date: _____

Patient Name _____ Date of Birth _____

Patient Birth History ■ Don't know birth history

Birth weight _____ Was the baby born at term? _____ OR _____ weeks
Were there any prenatal or neonatal complications?
❑ Yes ❑ No Explain _____

Was a NICU stay required? ❑ Yes ❑ No Explain _____

Was the delivery ❑ Vaginal ❑ Cesarean If cesarean, why? _____

Was initial feeding ❑ Formula ❑ Breast milk ❑ How long breastfed? _____ mos

During pregnancy, did mother
Use tobacco ❑ Yes ❑ No Drink alcohol ❑ Yes ❑ No
Use drugs or medications ❑ Yes ❑ No ❑ Use 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 _____

Past History DK = don't know N/A = not applicable

Does your child have, or has your child ever had,

Chickenpox	❑ Yes	❑ No	❑ DK	❑ N/A	When _____
Frequent ear infections	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Problems with ears or hearing	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Nasal allergies/Hay fever	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Problems with eyes or vision	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Any heart problem or heart murmur	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Anemia or bleeding problem	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Blood transfusion	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Frequent abdominal pain	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Constipation requiring doctor visits	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Recurrent urinary tract infections and problems	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Congenital cataracts/retinoblastoma	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Metabolic/genetic disorders	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Cancer	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Kidney disease or urologic malformations	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Bedwetting (after 7 years old)	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Sleep problems; snoring	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Chronic or recurrent skin problems (e.g., acne, eczema)	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Frequent headaches	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Convulsions or other neurologic problems	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Obesity	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Diabetes	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Thyroid or other endocrine problems	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
High blood pressure	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
History of serious injuries/fractures/concussions	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Use of alcohol or drugs	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Tobacco use	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
ADHD/anxiety/mood problems/depression	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Developmental delay	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Dental decay/cavaties	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
History of family violence	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
Sexually transmitted infections	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____
(For girls) Problems with her periods	❑ Yes	❑ No	❑ DK	❑ N/A	Explain _____

Has had first period ❑ Yes ❑ No Age of first period _____
Any other significant problems _____