Casas Adobes Pediatrics 7600 N. LaCholla Blvd., Tucson, AZ 85741

Initial History Questionnaire

Name: Last, First

FORM COMPLETED BY	DATE COMPLETED	BIRTH DATE	AGE	SEX
				M F

Household

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

Name	Relationship to child	Birth date	Health Problems	Occupation

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

If mother and father 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? ______

What languages are spoken in the home?
☐ English ☐ Spanish ☐ Other ______

Birth History

Did mother have any illness or problem with the pregnancy? ☐ Yes ☐ No Explain ______
During the pregnancy did mother use medications, drugs, smoke or drink alcohol? ☐ Yes ☐ No Explain ______
Was the delivery ☐ Vaginal? ☐ C-section?
Was the baby ☐ Term? ☐ Early? Gestational Age? ______ weeks
What was the baby's birth weight? ______ lbs ______ oz.
Did your baby have any problems right after birth? ☐ Yes ☐ No Explain ______
What was the initial feeding? ☐ Breast ☐ Formula
Did your baby pass the hearing screen? ☐ Yes ☐ No
Did your baby get the Hepatitis B vaccine? ☐ Yes ☐ No
Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain ______

General

Do you consider your child to be in good 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 ______
Are your child's immunizations up-to-date? ☐ Yes ☐ No ☐ I don't know
List all your child's current medications:

Name ______ Dose ______ Frequency ______
Name ______ Dose ______ Frequency ______
Name ______ Dose ______ Frequency ______

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 ______
If your child is in school:
What grades does your child get? ☐ Low ☐ Average ☐ High
Does your child have behavior problems in school? ☐ Yes ☐ No Explain ______
Has he/she failed or repeated a grade in school? ☐ Yes ☐ No Explain ______
Is he/she in special or resource classes? ☐ Yes ☐ No Explain ______

Name ______________________________ Birth Date ____________________

Patient Past History

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

Condition	Yes	No	
Chickenpox	☐ Yes	☐ No	When ____
Frequent ear infections	☐ Yes	☐ No	Explain ____
Problems with ears or hearing	☐ Yes	☐ No	Explain ____
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, bleeding problem or 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 5 years old)	☐ Yes	☐ No	Explain ____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain ____
(For girls) Are there problems with her periods?	☐ Yes	☐ No	Explain ____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ Yes	☐ No	Explain ____
Sprains or fractures	☐ Yes	☐ No	Explain ____
Frequent headaches	☐ Yes	☐ No	Explain ____
Convulsions or other neurologic problem	☐ Yes	☐ No	Explain ____
Concussion or head trauma	☐ Yes	☐ No	Explain ____
Diabetes	☐ Yes	☐ No	Explain ____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain ____
Obesity or Eating Disorder	☐ Yes	☐ No	Explain ____
Use of alcohol or drugs	☐ Yes	☐ No	Explain ____
Any other significant problem	☐ Yes	☐ No	Explain ____

____

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____

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who ____	Comments ____
Nasal allergies	☐ Yes	☐ No	Who ____	Comments ____
Asthma	☐ Yes	☐ No	Who ____	Comments ____
Sudden Death	☐ 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 / 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 ____
Epilepsy or convulsions	☐ Yes	☐ No	Who ____	Comments ____
Alcohol or drug abuse	☐ Yes	☐ No	Who ____	Comments ____
Mental Illness	☐ Yes	☐ No	Who ____	Comments ____
Mental retardation	☐ Yes	☐ No	Who ____	Comments ____
Immune problems, HIV or AIDS	☐ Yes	☐ No	Who ____	Comments ____

Additional family history ______________________________

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