Initial History Questionnaire						Name ID NUMBER					
ORM COMPLETED BY		DATE COMP	PLETED			BIRTH DATE			AGE		
Household											M F
	iving in the child's home.					Are there siblings	not listed? If	so please list	their nam	les ages an	d where
							Are there siblings not listed? If so, please list their names, ages, and where they live.				
Name	Relationship to child	Birth date	Health problems								
						What is the child	's living situat	ion if not with	both biol	ogical parer	nts?
						□ Lives with adop	•			•	
						Lives with fost	-			•	
						If one or both pa	rents are not	living in the h	ome, how	often does	the child se
						the parent(s) not		•			
Diuth Llistou		1.1.1									
	'y ■ Don't know birth										
-	Was the baby born at t		OR	w	veeks	Was the delivery	∐ Vaginal	□ Cesarean	lf cesar	ean, why?	
	natal or neonatal complic										
JYes ∐No Ex	plain										
		F 1 ·								1	13
Nas a NICU stay re	equired? 🗌 Yes 🗌 No	e Explain	I			Was initial feeding	-			•	d?
		o Explain	I			Did your baby go	home with r	nother from th	ne hospital	!?	
During pregnancy, di	id mother						home with r	nother from th	ne hospital	!?	
During pregnancy, di Jse tobacco □Ye	id mother es □No Dri	ink alcohol	□ Yes	□ No		Did your baby go	home with r	nother from th	ne hospital	!?	
During pregnancy, di Jse tobacco 🛛 Ye Jse drugs or medica	id mother es □No Dri ations □Yes □No	ink alcohol	□ Yes prenatal vit	□ No amins		Did your baby go	home with r Explain	nother from th	ne hospital	!?	
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Biological Family History (Continued from front side.) DK = don't know

Liver disease	🗆 Yes	🗆 No	🗆 DK	Who	_ Comments
Kidney disease	🗆 Yes	🗆 No	🗆 DK	Who	Comments
Diabetes (before 55 years old)	🗆 Yes	🗆 No	🗆 DK	Who	_ Comments
Bed-wetting (after 10 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	🗆 Yes	🗆 No	🗆 DK	Who	_ Comments
Immune problems, HIV, or AIDS	🗆 Yes	🗆 No	🗆 DK	Who	
Tobacco use	🗆 Yes	🗆 No	🗆 DK	Who	_ Comments
Additional family history					

Past History DK = don't know

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

This American Academy of Pediatrics Initial History Questionnaire is consistent with Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents, 3rd Edition. The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Copyright © 2010 American Academy of Pediatrics. All rights reserved. No part of this publication may

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