Initial History Questionnaire

Household
Please list all those living in the child’s home.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship to child</th>
<th>Birth date</th>
<th>Health problems</th>
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</tbody>
</table>

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 ______. Was the baby born at term? ______ OR ______ weeks. Were there any prenatal or neonatal complications?

- Yes
- No

Was a NICU stay required?

- Yes
- No

During pregnancy, did mother

- Use tobacco
  - Yes
  - No
- Drink alcohol
  - Yes
  - No
- Use drugs or medications
  - Yes
  - No
- Used prenatal vitamins

What

When

Was the delivery

- Vaginal
- Cesarean

If cesarean, why?

Was initial feeding

- Formula
- Breast milk

How long breastfed?

Did your baby go home with mother from the hospital?

- Yes
- No

General

DK = don’t know

Do you consider your child to be in good health?

- Yes
- No

Does your child have any serious illnesses or medical conditions?

- Yes
- No

Has your child had any surgery?

- Yes
- No

Has your child ever been hospitalized?

- Yes
- No

Is your child allergic to medicine or drugs?

- Yes
- No

Do you feel your family has enough to eat?

- Yes
- No

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

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes</th>
<th>No</th>
<th>DK</th>
<th>Who</th>
<th>Comments</th>
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</thead>
<tbody>
<tr>
<td>Liver disease</td>
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<td>Kidney disease</td>
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<td>Diabetes (before 55 years old)</td>
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<td>Bed-wetting (after 10 years old)</td>
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<td>Obesity</td>
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<td>Epilepsy or convulsions</td>
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<td>Alcohol abuse</td>
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<td>Drug abuse</td>
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<td>Mental illness/depression</td>
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<td>Developmental disability</td>
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<td>Immune problems, HIV, or AIDS</td>
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<td>Tobacco use</td>
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<tr>
<td>Additional family history</td>
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### Past History  
DK = don’t know

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

- Chickenpox  
- Frequent ear infections  
- Problems with ears or hearing  
- Nasal allergies  
- Problems with eyes or vision  
- Asthma, bronchitis, bronchiolitis, or pneumonia  
- Any heart problem or heart murmur  
- Anemia or bleeding problem  
- Blood transfusion  
- HIV  
- Organ transplant  
- Malignancy/bone marrow transplant  
- Chemotherapy  
- Frequent abdominal pain  
- Constipation requiring doctor visits  
- Recurrent urinary tract infections and problems  
- Congenital cataracts/retinoblastoma  
- Metabolic/Genetic disorders  
- Cancer  
- Kidney disease or urologic malformations  
- Bed-wetting (after 5 years old)  
- Sleep problems; snoring  
- Chronic or recurrent skin problems (eg, acne, eczema)  
- Frequent headaches  
- Convulsions or other neurologic problems  
- Obesity  
- Diabetes  
- Thyroid or other endocrine problems  
- High blood pressure  
- History of serious injuries/fractures/concussions  
- Use of alcohol or drugs  
- Tobacco use  
- ADHD/anxiety/mood problems/depression  
- Developmental delay  
- Dental decay  
- History of family violence  
- Sexually transmitted infections  
- Pregnancy  
- (For girls) Problems with her periods  
  - Has had first period  
  - 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.