



Washingtonville Pediatrics
Boston Children's Health Physicians
 Until every child is well

INITIAL HISTORY QUESTIONNAIRE

Name _____

Birth Date _____ Age: _____ M _____ F _____

Form Completed By _____ Date _____

How did you hear about us? _____

Who can we thank for referring you? _____

Illness/Injuries

- Do you consider your child to be in good health? Y ___ N ___ Explain _____
- Does your child have a serious illness/medical condition? Y ___ N ___ Explain _____
- Any chronic/recurrent skin problem (acne, eczema, etc.)? Y ___ N ___ Explain _____
- Use of alcohol or drugs? Y ___ N ___ Explain _____
- Nasal allergies? Y ___ N ___ Explain _____
- Anemia or bleeding problem? Y ___ N ___ Explain _____
- Asthma, bronchitis, bronchiolitis or pneumonia? Y ___ N ___ Explain _____
- Bed-wetting (after 5 years old) Y ___ N ___ Explain _____
- Bladder or kidney infection? Y ___ N ___ Explain _____
- Blood transfusion? Y ___ N ___ Explain _____
- Chickenpox? Y ___ N ___ Explain _____
- Constipation requiring doctor visits? Y ___ N ___ Explain _____
- Convulsions or other neurologic problem? Y ___ N ___ Explain _____
- Diabetes? Y ___ N ___ Explain _____
- Frequent ear infections? Y ___ N ___ Explain _____
- Problems with ears/hearing? Y ___ N ___ Explain _____
- Problems with eyes/vision? Y ___ N ___ Explain _____
- Frequent abdominal pain? Y ___ N ___ Explain _____
- Frequent headaches Y ___ N ___ Explain _____
- Any heart problem or heart murmur? Y ___ N ___ Explain _____
- Thyroid or other endocrine problem? Y ___ N ___ Explain _____
- Any other significant problem? Y ___ N ___ Explain _____
- Has your child had serious injuries/accidents? Y ___ N ___ Explain _____

Surgery/Hospitalization

- Has your child had any surgery? Y ___ N ___ Explain _____
- Is your child allergic to any medicines or drugs? Y ___ N ___ Explain _____
- Has your child ever been hospitalized? Y ___ N ___ Explain _____

OB-GYN (For Girls)

- Has she started menstrual periods? Y ___ N ___ Explain _____
- Are there problems with her periods? Y ___ N ___ Explain _____

Birth History

Was the baby born at term? Y ___ N ___ Early? ___ Late? ___
If early, how many weeks gestation? _____

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

Birth Weight? _____

Did mother have any illness or problem with her pregnancy? Y ___ N ___ Explain: _____

During pregnancy, did mother? Smoke? Y ___ N ___ Drink Alcohol? Y ___ N ___
Use drugs/medications? Y ___ N ___ What? _____ When? _____

Family History

Have any family members had the following:

Immune problem, HIV or AIDS?	Y ___ N ___	Who? _____	Comments _____
Alcohol abuse?	Y ___ N ___	Who? _____	Comments _____
Nasal allergies?	Y ___ N ___	Who? _____	Comments _____
Anemia?	Y ___ N ___	Who? _____	Comments _____
Asthma?	Y ___ N ___	Who? _____	Comments _____
Bed-wetting (after 10 yrs old)?	Y ___ N ___	Who? _____	Comments _____
Birth defects?	Y ___ N ___	Who? _____	Comments _____
Bleeding disorder?	Y ___ N ___	Who? _____	Comments _____
Cancer?	Y ___ N ___	Who? _____	Comments _____
Diabetes (before 50 yrs old)?	Y ___ N ___	Who? _____	Comments _____
Drug abuse?	Y ___ N ___	Who? _____	Comments _____
Epilepsy or convulsions?	Y ___ N ___	Who? _____	Comments _____
Deafness?	Y ___ N ___	Who? _____	Comments _____
Heart disease (before 50 yrs old)?	Y ___ N ___	Who? _____	Comments _____
High cholesterol?	Y ___ N ___	Who? _____	Comments _____
High blood pressure (before 50 yrs old)?	Y ___ N ___	Who? _____	Comments _____
Kidney disease?	Y ___ N ___	Who? _____	Comments _____
Liver disease?	Y ___ N ___	Who? _____	Comments _____
Mental illness?	Y ___ N ___	Who? _____	Comments _____
Intellectual disability?	Y ___ N ___	Who? _____	Comments _____
Migraines?	Y ___ N ___	Who? _____	Comments _____
Scoliosis?	Y ___ N ___	Who? _____	Comments _____
Thyroid disorder?	Y ___ N ___	Who? _____	Comments _____
Tuberculosis?	Y ___ N ___	Who? _____	Comments _____

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Thyroid disorder?	Y ___ N ___	Who? _____	Comments _____
Tuberculosis?	Y ___ N ___	Who? _____	Comments _____

Home Environment:

Mother's Full Name _____ Occupation _____

Father's Full Name _____ Occupation _____

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

Name	Relationship to Child	Birth Date	Health Problems
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are there siblings not listed? If so, please list their names, 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 in the home, how often does he/she see the parent(s) that are not in the home?

Is your child exposed to smoke in the home? Y___ N___ Explain _____
Are there pets in the home? Y___ N___ Explain _____

Development:

Are you concerned about your child's:
Attention span? Y___ N___ Explain _____
Mental or emotional development? Y___ N___ Explain _____
Physical development? Y___ N___ Explain _____

If your child is in school:

How is his/her behavior in school?

How is he/she doing in academic subjects?

Is he/she in special or resource classes?

Has he/she failed or repeated a grade in school?

