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

Question	Y	N	Explain
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

Question	Y	N	Explain
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)

Question	Y	N	Explain
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:

Condition	Y	N	Who?	Comments
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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Cancer?	Y___	N___	Who? ________	Comments ________
Diabetes (before 50 yrs old)?	Y___	N___	Who? ________	Comments ________
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High cholesterol?	Y___	N___	Who? ________	Comments ________
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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? ________	

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?

____

____