Initial History Questionnaire					Name	Name		
					ID NUMBER			
FORM COMPLETED BY DATE COMPLETED				BIRTH DATE	AGE			
TOTAL CONTRELETED DI						M F		
Household								
Please list all those li	ving in the child's home.				Are there siblings not listed? If so, please list their names, ages, and where			
	Relationship Birth Health				they live			
Name	to child	date         problems           What is the child's living situation if not with both biological particular						
					_	ts 🗌 Joint custody 🗌 Single custody		
					Lives with foster family	ot living in the home, how often does the child se		
					the parent(s) not in the hom	-		
<b>Birth Histor</b>	y ∎Don't know birth	history						
Birth weight	Was the baby born at te	erm?	OR	we	ks Was the delivery 🗌 Vagina	l 🗌 Cesarean If cesarean, why?		
Nere there any pre	natal or neonatal complica	ations?						
Yes No Ex	plain							
Was a NICU stay re	quired? 🗌 Yes 🗌 No	Explain				la 🗆 Breast milk How long breastfed?		
					Did your baby go home with	mother from the hospital?		
During pregnancy, di	a morner				Tes INO Explain			
		nk alcohol	Yes	No				
Use tobacco 🗌 Ye	es 🗌 No 🛛 Drin		☐ Yes orenatal vita					
Jse tobacco □ Ye Jse drugs or medica	es 🗆 No 🛛 Drin ations 🗌 Yes 🗌 No	Used p	orenatal vita	amins				
Jse tobacco □ Ye Jse drugs or medica	as 🗌 No Drin Litions 🗌 Yes 🗌 No Who	Used p	orenatal vita	amins				
Jse tobacco 🗆 Ye Jse drugs or medica What General DK	as 🗌 No Drin Litions 🗌 Yes 🗌 No Who . = don't know	□ Used p en	orenatal vita	amins				
Use tobacco	as No Drin ations Yes No when the don't know ar child to be in good heal	Used p en lth? I Y	erenatal vita es □Nc	amins				
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# American Academy of Pediatrics



### (Biological Family History continued on back side.)

## Initial History Questionnaire

### **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	Comments
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	2 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	2 Yes	No	🗆 DK	Explain		
(For girls) Problems with her periods	Yes	No	DK	Explain		
Has had first period 🗌 Yes 🗌 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 be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from the publisher.