

Initial History Questionnaire

Form Completed By:	Name:		
Initial Date Completed:	ID Number:		
Date(s) Updated:	Birth Date:	Age:	Sex: M F

GENERAL

Do you consider your child to be in good health? Yes No Don't know Explain: _____

Does your child have any special health care needs? Yes No Don't know Explain: _____

Has your child ever been hospitalized? Yes No Don't know Explain: _____

Is your child allergic to medicine or drugs? Yes No Don't know Explain: _____

SOCIAL HISTORY

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

Name	Relationship to Child	Birth Date/Age

Please list other siblings not living in the home.

Name	Birth Date/Age	Where are they living?

Does the child live with both biological parents? Yes No

If no, what is the child's current living situation?

Single-parent custody Joint custody Adoptive family

Other family members: _____ Foster care

How often does the child have visitation with parent(s) not living in the home?

BIRTH HISTORY

Birth weight: _____

Full-term Preterm _____ weeks Post-term _____ weeks

Delivery: Vaginal Cesarean Reason: _____

Any complications during birth or after birth? No Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

No Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins? Yes No Unknown

Smoke or use e-cigarettes? Yes No Unknown

Drink alcohol? Yes No Unknown

Use marijuana? Yes No Unknown

Use illicit drugs? Yes No Unknown

Take other medications? Yes No Unknown

If yes, please list: _____

Blood type:

Mother: _____ Unknown

Baby: _____ Unknown

Mother's lab results:

Hepatitis B Pos Neg Unknown

HIV Pos Neg Unknown

Group B streptococcus (GBS) Pos Neg Unknown

After birth, did the baby get:

Vitamin K shot? Yes No Unknown

Erythromycin eye ointment? Yes No Unknown

Hepatitis B shot? Yes No Unknown

How was the baby fed? Bottle formula Bottle breast milk

Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? Yes

No Explain: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



The recommendations in this questionnaire 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. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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HE0564

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Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Eye problems, cataracts, or retinoblastoma				
Vision impairment or concerns				
Nasal allergies (dust, pets, or environmental)				
Frequent ear infections				
Hearing loss or concerns				
Multiple cavities or problems with teeth				
Frequent colds or sore throats				
Asthma, wheezing, or breathing problems				
Bronchitis, bronchiolitis, or pneumonia				
Heart murmur or other heart problems				
High blood pressure				
Frequent stomach pain				
Constipation needing medical treatment				
Food allergies or intolerance (eg, milk, gluten)				
Feeding issues or underweight				
Overweight or obesity				
Urinary tract infections				
Bed-wetting (after 5 years old)				
Kidney, ureter, or bladder problems				
Serious injuries or fractures				
Bone, joint, or muscle problems				
Frequent headaches or dizziness				
Concussion or head injury				
Convulsions, seizures, or neurological issues				
Sleep problems or snoring				
Skin rashes, eczema, or hives				
Acne				
Thyroid or other endocrine problems				
Diabetes				
Metabolic/genetic disorders				
Anemia or bleeding problems				
Cancer or chemotherapy				
Bone marrow or organ transplant				

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PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

Condition	DK	No	Yes	Details
Blood transfusion				
HIV or AIDS				
Chickenpox or zoster (shingles)				
Developmental delays (speech or motor)				
School problems or learning difficulties				
ADHD or behavioral concerns				
Anxiety, depression, or mood problems				
Tobacco, alcohol, or drug use				
Exposure to family violence				
Pregnancy or miscarriage				
Sexually transmitted infections				
Females: issues with periods				
Age of first period:				

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? No Yes If yes, please provide details below.

Surgery/Procedure	Date of Surgery/Child's Age	Where Completed	Details

Other surgical/procedural problems (Please list.)

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FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

Condition	DK	No	Yes	Who?	Details
Anemia or bleeding problems					
Asthma					
Allergies					
Alcohol use problems					
Bed-wetting (after age 10 years)					
Cancer (before age 55 years)					
Childhood hearing loss					
Dental decay or multiple cavities					
Depression or anxiety					
Developmental disability					
Diabetes					
Heart attack (myocardial infarction)					
Heart disease (before age 55 years)					
High blood pressure					
High cholesterol					
HIV or AIDS					
Kidney disease					
Liver disease					
Mental health conditions					
Obesity					
Seizures or epilepsy					
Stroke					
Substance use problems					
Sudden death (before age 50 years)					
Thyroid or other endocrine disease					
Tobacco use problems					
Tuberculosis					
Vision or eye problems					

Other medical problems (Please list.)

PRINT NAME.	SIGNATURE
Provider 1	
Provider 2	

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Guidelines for Health Supervision of
Infants, Children, and Adolescents,
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