

Visit Documentation Form User Guide

for Initial History Questionnaire

The newly revised American Academy of Pediatrics (AAP) Initial History Questionnaire is designed to provide health care professionals with a medical background for the patient and the patient's family to help inform medical decisions going forward. Intended to be completed by a caregiver of the pediatric patient, this form addresses a number of important areas. In addition, the information gathered on the form can support the documentation of additional activities within the initial visit to support appropriate coding and secure appropriate payment for the practitioner's activities.

With an increase in pay-for-performance programs, quality improvement initiatives, audits, and legal review, documentation is more critical than ever. The AAP Initial History Questionnaire will support the documentation process. By providing an organized and consistent layout, clinicians can use the form for more effective documentation, which can improve performance, limit liability, and support efforts to obtain appropriate payment for services. While the electronic medical record will be the future for most medical practices, this Initial History Questionnaire provides a clear, concise way for practitioners to establish a more complete history on each patient and family.

Key Features

Comprehensive

The Initial History Questionnaire provides families the opportunity to inform their health care practitioner of a more complete family history for their children. The form is robust, addressing a number of different areas, including household description, birth and newborn history, general health issues, developmental issues and concerns, biological family history, and past medical history for the child. The Initial History Questionnaire uses check boxes where feasible, but space is provided for written information where appropriate.

Reduced Duplication

To decrease the duplication of needed information, the Initial History Questionnaire is referenced extensively within other components of the AAP collection of documentation products. These include references within each well-child Visit Documentation Form and the Problem Visit form.

Universality

No documentation form will completely satisfy all practitioners. However, the Initial History Questionnaire addresses the information that pediatricians most frequently review in a patient's history. While efforts have been made to address common documentation requirements for Early and Periodic Screening, Diagnosis, and Treatment, states vary in their required elements. Additional elements may be needed to meet your state's requirements.

Peer Reviewed

The forms have been reviewed by multiple committees of the AAP, including the Committee on Adolescence, Committee on Coding and Nomenclature, Committee on Medical Liability and Risk Management, Committee on Practice and Ambulatory Medicine, and Council on Clinical Information Technology.

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Pediatric-specific family and past history.

Identifies who is providing the patient's history.

Initial History Questionnaire

FORM COMPLETED BY _____ DATE COMPLETED _____

Name _____

ID NUMBER _____

BIRTH DATE _____

AGE _____

M F

Household

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. _____

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 Explain _____

Was a NICU stay required? Yes No Explain _____

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 Explain _____

General

DK = don't know
 Do you consider your child to be in good health? Yes No DK Explain _____

Does your child have any serious illnesses or medical conditions? Yes No DK Explain _____

Has your child had any surgery? Yes No DK Explain _____

Has your child ever been hospitalized? Yes No DK Explain _____

Is your child allergic to medicine or drugs? Yes No DK Explain _____

Do you feel your family has enough to eat? Yes No DK Explain _____

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 _____

Improved information on household structure.

Identifies perinatal risk factors.

Check boxes with space for explanation.

Form aligned with recommendations in the Bright Futures Guidelines, 3rd Edition.

American Academy of Pediatrics
 DEDICATED TO THE HEALTH OF ALL CHILDREN™



Initial History Questionnaire

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.
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