R & R Pediatrics

Initial History Questionnaire: **Chart # _____**

Child Name: First Name: _____ Last (Family) Name: _____
DOB: _____ Age: _____ Sex: ☐ Male ☐ Female

Completed by _____ Date _____ Relation to child _____MD review _____

☐ Check this box if biological family history is unknown ☐ Check this box if patient adopted or in foster care

Family: (please list all those living in the child's home)

Name	Relationship	Age	Health Problems

Child's Living Situation: If not living with both biological parents who has the custody?
☐ With both parents ☐ With Mother ☐ With Father ☐ With adoptive parents ☐ With Foster family ☐ Group Home ☐ Grand Parents
☐ Single Custody ☐ Joint Custody
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home? _____

Current General Medical History: (explain if answer is yes to any of the questions below)
. Do you consider your child to be in good health? ☐ Yes ☐ No Explain _____
. **Drug allergies** ☐ No ☐ Yes Explain _____
. Has your child ever been Hospitalized ☐ No ☐ Yes Explain_____?
. **Any surgeries** ☐ No ☐ Yes Explain_____
. Any serious illness/medical condition ☐ No ☐ Yes Explain_____
. On Any medicines ☐ No ☐ Yes Explain_____
. Any concerns ☐ No ☐ Yes Explain_____
. Do you & you're your family has enough to eat? ☐ Yes ☐ No _____

Social History:
. Smokers in the home ☐ No ☐ Yes . Smoke detectors ☐ Yes ☐ No . Pets in the home _____ . Attends Day care ☐ Yes ☐ No

. **Water Source** ☐ Well water ☐ City water ☐ Bottled water without Fluoride ☐ Bottled water with Fluoride ☐ Nursery water

Prenatal History: During pregnancy did mother
. Use Tobacco ☐ No ☐ Yes . Drink alcohol ☐ No ☐ Yes
. Use drugs/medications ☐ No ☐ Yes what _____ When _____
. Used prenatal vitamins ☐ Yes ☐ No Any other illness ☐ No ☐ Yes, if yes explain _____

Birth History: ☐ Vaginal delivery ☐ C-section, why? _____
☐ Full term (>37weeks) or ☐ Premature (<37 weeks), how many weeks of pregnancy? _____
. Were there any Complications? _____
. Was baby admitted to NICU? ☐ No ☐ Yes ,Explain _____
. Birth weight _____ Length _____ Head _____
. Initial feeding was ☐ Breast milk ☐ Formula How long breastfed? _____
. Did your baby go home with mother from the hospital? ☐ Yes ☐ No Explain _____
_____

Initial History Contd.

Biological Family History: (**F** = Father, **M** = Mother, **PGF** = Paternal Grand Father, **PGM** = Paternal Grand Mother, **MGF** = Maternal Grand Father, **MGM** = Maternal Grand Mother, **B** = Brother, **S** = Sister, **OT** = Others)

Disease	YES	NO	Who	Disease	YES	NO	Who
. Asthma				. Eczema			
. Anemia				. Epilepsy			
. Allergies				. Heart Disease <55 years			
. Alcohol Abuse				. Hypertension			
. Breast Cancer				. Hypercholesterolemia			
. Bed wetting				. Kidney Disease			
. Bleeding Disorder				. Liver Disease			
. Cancer				. Lupus (SLE)			
. Deafness Childhood				. Leukemia			
. Diabetes				. Migraine			
. Drug abuse				. Mental Illness			
. Dental Caries				. HIV/AIDS			
. Developmental Delay				. Tobacco Use			
. Immune (HIV/AIDS)				. Tuberculosis			

Past History: Problems other than listed below? _____

Disease	YES	NO	Explain	Disease	YES	NO	Explain
. Acne				. Ear infections, frequent			
. Allergies				. Ear Tubes			
. Anemia				. Emotional Problems			
. Asthma				. Febrile Seizures			
. Anaphylaxis				. Frequent abdominal pain			
. Alcohol problems				. Growth problems			
. ADD/ADHD				. Genetic problems			
. Anxiety				. Glaucoma			
. Bed-wetting				. Headache/Migraine			
. Bleeding Problems				. HIV/AIDS			
. Blood Transfusion				. Hypertension			
. Behavioral Problems				. Heart Attack			
. Cancer				. Hearing loss			
. Crohn's Disease				. Heart Murmur			
. Constipation, chronic				. Kidney Problems/UTIs			
. Chickenpox				. Kawasaki Disease			
. Chronic Cough				. Learning Problems			
. Colds, frequent				. Leukemia			
. Cystic Fibrosis				. Lupus (SLE)			
. Chemotherapy				. Migraine			
. Cataracts				. Malignancy			
. Diabetes				. Organ Transplant			
. Drug abuse				. Obesity			
. Dental Caries				. Pregnancy			
. Developmental Delays				. STD/STIs			
.Eczema				. Sleeping problems			
. Epilepsy				. Snoring			
. Enuresis				. Thyroid Problems			
. Endocrine Problems				. Tobacco use			
. Eye Problems				. Others			