

Lakeside Pediatric and Adolescent Medicine Initial History Questionnaire

Patient Name: _____ Birth Date: - __/__/____ M ___ F ___

Form Completed By: _____ Date Completed: _____

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: _____

___ 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 Weight _____ Was the baby born at term _____ OR _____ weeks

Time of birth _____ AM/PM Was the delivery ___ Vaginal

Were there any prenatal or neonatal complications?

___ Cesarean, if cesarean, Why? _____

___ Yes ___ No Explain _____

Was a NICU stay required? ___ Yes ___ No Explain _____

Was initial feeding ___ Formula ___ Breast Milk How long breast fed? _____

During pregnancy, did mother:

Did your baby go home with mother from the hospital?

Use tobacco ___ Yes ___ No Drink alcohol ___ Yes ___ No

___ Yes ___ No Explain _____

Use drugs or medications ___ Yes ___ No Used prenatal vitamins ___ Yes ___ No

What _____ When _____

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?

	___ Yes ___ No ___ DK	Who _____	Comments _____
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 age 55)	___ Yes ___ No ___ DK	Who _____	Comments _____
High cholesterol	___ 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 age 55)	___ Yes ___ No ___ DK	Who _____	Comments _____
Liver disease	___ Yes ___ No ___ DK	Who _____	Comments _____
Kidney disease	___ Yes ___ No ___ DK	Who _____	Comments _____
Diabetes (before age 55)	___ Yes ___ No ___ DK	Who _____	Comments _____
Bed-wetting (after age 10)	___ Yes ___ No ___ DK	Who _____	Comments _____
Obesity	___ Yes ___ No ___ DK	Who _____	Comments _____

BIOLOGICAL FAMILY HISTORY (CONTINUED FROM FRONT SIDE) DK = don't know

Epilepsy or convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Immune problems,	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Additional family history	_____		

PAST HISTORY DK = don't know

Does your child have, or has your child ever had:

Chicken pox	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
HIV, or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Metabolic/genetic disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Bed-wetting, (after 5 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems, (eg, acne, eczema)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Convulsions, or other neurologic problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Diabetes (before age 55)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Explain _____
Has had first period	<input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first period _____
Any other significant problem	_____	