INITIAL HISTORY QUESTIONNAIRE

Name ____________________________________________

Birth Date ____________________________ Age: __________ M _____ F _____

Form Completed By ____________________________ Date ________________________

How did you hear about us? ____________________________________________________________

Who can we thank for referring you? ______________________________________________________

Illness/Injuries

Do you consider your child to be in good health? Y _____ N _____ Explain _______________

Does your child have a serious illness/medical condition? Y _____ N _____ Explain _______________

Any chronic/recurrent skin problem (acne, eczema, etc.)? Y _____ N _____ Explain _______________

Use of alcohol or drugs? Y _____ N _____ Explain _______________

Nasal allergies? Y _____ N _____ Explain _______________

Anemia or bleeding problem? Y _____ N _____ Explain _______________

Asthma, bronchitis, bronchiolitis or pneumonia? Y _____ N _____ Explain _______________

Bed-wetting (after 5 years old) Y _____ N _____ Explain _______________

Bladder or kidney infection? Y _____ N _____ Explain _______________

Blood transfusion? Y _____ N _____ Explain _______________

Chickenpox? Y _____ N _____ Explain _______________

Constipation requiring doctor visits? Y _____ N _____ Explain _______________

Convulsions or other neurologic problem? Y _____ N _____ Explain _______________

Diabetes? Y _____ N _____ Explain _______________

Frequent ear infections? Y _____ N _____ Explain _______________

Problems with ears/hearing? Y _____ N _____ Explain _______________

Problems with eyes/vision? Y _____ N _____ Explain _______________

Frequent abdominal pain? Y _____ N _____ Explain _______________

Frequent headaches Y _____ N _____ Explain _______________

Any heart problem or heart murmur? Y _____ N _____ Explain _______________

Thyroid or other endocrine problem? Y _____ N _____ Explain _______________

Any other significant problem? Y _____ N _____ Explain _______________

Has your child had serious injuries/accidents? Y _____ N _____ Explain _______________

Surgery/Hospitalization

Has your child had any surgery? Y _____ N _____ Explain _______________

Is your child allergic to any medicines or drugs? Y _____ N _____ Explain _______________

Has your child ever been hospitalized? Y _____ N _____ Explain _______________

OB-GYN (For Girls)

Has she started menstrual periods? Y _____ N _____ Explain _______________

Are there problems with her periods? Y _____ N _____ Explain _______________
Birth History
Was the baby born at term? Y  N  Early?  Late?  If early, how many weeks gestation?
Was the delivery Vaginal?  Cesarean?  If cesarean, why?
Birth Weight?
Did mother have any illness or problem with her pregnancy? Y  N  Explain:
During pregnancy, did mother?  Smoke? Y  N  Drink Alcohol? Y  N
Use drugs/medications? Y  N  What?  When?

Family History
Have any family members had the following:
Immune problem, HIV or AIDS? Y  N  Who?  Comments
Alcohol abuse? Y  N  Who?  Comments
Nasal allergies? Y  N  Who?  Comments
Anemia? Y  N  Who?  Comments
Asthma? Y  N  Who?  Comments
Bed-wetting (after 10 yrs old)? Y  N  Who?  Comments
Birth defects? Y  N  Who?  Comments
Bleeding disorder? Y  N  Who?  Comments
Cancer? Y  N  Who?  Comments
Diabetes (before 50 yrs old)? Y  N  Who?  Comments
Drug abuse? Y  N  Who?  Comments
Epilepsy or convulsions? Y  N  Who?  Comments
Deafness? Y  N  Who?  Comments
Heart disease (before 50 yrs old)? Y  N  Who?  Comments
High cholesterol? Y  N  Who?  Comments
High blood pressure (before 50 yrs old)? Y  N  Who?  Comments
Kidney disease? Y  N  Who?  Comments
Liver disease? Y  N  Who?  Comments
Mental illness? Y  N  Who?  Comments
Intellectual disability? Y  N  Who?  Comments
Migraines? Y  N  Who?  Comments
Scoliosis? Y  N  Who?  Comments
Thyroid disorder? Y  N  Who?  Comments
Tuberculosis? Y  N  Who?  Comments
Birth History
Was the baby born at term? Y __ N __
Early? __ Late? __
If early, how many weeks gestation? ____________

Was the delivery Vaginal? __ Cesarean? __
If cesarean, why? ________________________________

Birth Weight? ________________________________

Did mother have any illness or problem with her pregnancy? Y __ N __
Explain: _______________________________________

During pregnancy, did mother? Smoke? Y __ N __
Drink Alcohol? Y __ N __
Use drugs/medications? Y __ N __
What? ___________________________ When? ___________

Family History
Have any family members had the following:
Immune problem, HIV or AIDS? Y __ N __ Who? ___________________________ Comments _______________________
Alcohol abuse? Y __ N __ Who? ___________________________ Comments _______________________
Nasal allergies? Y __ N __ Who? ___________________________ Comments _______________________
Anemia? Y __ N __ Who? ___________________________ Comments _______________________
Asthma? Y __ N __ Who? ___________________________ Comments _______________________
Bed-wetting (after 10 yrs old)? Y __ N __ Who? ___________________________ Comments _______________________
Birth defects? Y __ N __ Who? ___________________________ Comments _______________________
Bleeding disorder? Y __ N __ Who? ___________________________ Comments _______________________
Cancer? Y __ N __ Who? ___________________________ Comments _______________________
Diabetes (before 50 yrs old)? Y __ N __ Who? ___________________________ Comments _______________________
Drug abuse? Y __ N __ Who? ___________________________ Comments _______________________
Epilepsy or convulsions? Y __ N __ Who? ___________________________ Comments _______________________
Deafness? Y __ N __ Who? ___________________________ Comments _______________________
Heart disease (before 50 yrs old)? Y __ N __ Who? ___________________________ Comments _______________________
High cholesterol? Y __ N __ Who? ___________________________ Comments _______________________
High blood pressure (before 50 yrs old)? Y __ N __ Who? ___________________________ Comments _______________________
Kidney disease? Y __ N __ Who? ___________________________ Comments _______________________
Liver disease? Y __ N __ Who? ___________________________ Comments _______________________
Mental illness? Y __ N __ Who? ___________________________ Comments _______________________
Intellectual disability? Y __ N __ Who? ___________________________ Comments _______________________
Migraines? Y __ N __ Who? ___________________________ Comments _______________________
Scoliosis? Y __ N __ Who? ___________________________ Comments _______________________
Thyroid disorder? Y __ N __ Who? ___________________________ Comments _______________________
Tuberculosis? Y __ N __ Who? ___________________________ Comments _______________________
Home Environment:
Mother's Full Name ____________________________ Occupation ____________________________
Father's Full Name ____________________________ Occupation ____________________________

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

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<tr>
<th>Name</th>
<th>Relationship to Child</th>
<th>Birth Date</th>
<th>Health Problems</th>
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Are there siblings not listed? If so, please list their names, ages and where they live.

If mother and father are not living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not in the home, how often does he/she see the parent(s) that are not in the home?

Is your child exposed to smoke in the home? Y____ N____ Explain ____________________________
Are there pets in the home? Y____ N____ Explain ____________________________

Development:
Are you concerned about your child's:
- Attention span? Y____ N____ Explain ____________________________
- Mental or emotional development? Y____ N____ Explain ____________________________
- Physical development? Y____ N____ Explain ____________________________

If your child is in school:
How is his/her behavior in school?

How is he/she doing in academic subjects?

Is he/she in special or resource classes?

Has he/she failed or repeated a grade in school?