Acacia
FAMILY MEDICAL GROUP

Initial History Questionnaire

Name

Form completed by Date completed

Birth date Age M F

Household

Please list all those living in the childôs home.

Name	Relationship to child	Birth date	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live.

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

If one or both parents are not living at home, how often does He/she see the parent/parents not in the home?

Birth History

Birth weight _____

Was the baby born at term? _____ Early? _____ Late? _____

If early, how many weeksô gestation? _____

Did mother have any illness or problem with her pregnancy?

□ Yes □ No Explain_____

_____

During pregnancy, did mother

Smoke □ Yes □ No Drink alcohol □ Yes □ No

Use drugs or medications □ Yes □ No

What _____ When _____

Was the delivery □ Vaginal? □ Cesarean?

If cesarean, why? _____

Did your baby have any problems right after birth?

□ Yes □ No Explain _____

_____

Was initial feeding □ Breast? □ Bottle?

Did your baby go home with mother from the hospital?

□ Yes □ No Explain _____

_____

General

Do you consider your child to be in good health? □ Yes □ No Explain _____

Does your child have any serious illness or medical condition? □ Yes □ No Explain _____

Has your child had serious injuries or accidents? □ Yes □ No Explain _____

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

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

Allergies

Is your child allergic to any medicines or drugs? □ Yes □ No Explain _____

Development

Are you concerned about your childôs physical development? □ Yes □ No Explain _____

Are you concerned about your childôs mental or emotional development? □ Yes □ No Explain _____

Are you concerned about your childôs attention span? □ Yes □ No Explain _____

If your child is in school:

How is his/her behavior in school? _____

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

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? _____

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Family History

Have any family members had the following:

Deafness	☐ Yes	☐ No	Who_____	Comments_____
Nasal allergies	☐ Yes	☐ No	Who_____	Comments_____
Asthma	☐ Yes	☐ No	Who_____	Comments_____
Tuberculosis	☐ Yes	☐ No	Who_____	Comments_____
Heart disease (before age 50)	☐ Yes	☐ No	Who_____	Comments_____
High blood pressure (before age 50)	☐ Yes	☐ No	Who_____	Comments_____
High cholesterol	☐ Yes	☐ No	Who_____	Comments_____
Anemia	☐ Yes	☐ No	Who_____	Comments_____
Bleeding disorder	☐ Yes	☐ No	Who_____	Comments_____
Liver disease	☐ Yes	☐ No	Who_____	Comments_____
Kidney disease	☐ Yes	☐ No	Who_____	Comments_____
Diabetes (before age 50)	☐ Yes	☐ No	Who_____	Comments_____
Bed-wetting (after age 10)	☐ Yes	☐ No	Who_____	Comments_____
Epilepsy or convulsions	☐ Yes	☐ No	Who_____	Comments_____
Alcohol abuse	☐ Yes	☐ No	Who_____	Comments_____
Drug abuse	☐ Yes	☐ No	Who_____	Comments_____
Mental Illness	☐ Yes	☐ No	Who_____	Comments_____
Mental retardation	☐ Yes	☐ No	Who_____	Comments_____
Immune problems, HIV, or AIDS	☐ Yes	☐ No	Who_____	Comments_____

Additional family history: _____

Past History

Does your child have, or has he/she ever had:

Chickenpox	☐ Yes	☐ No	Explain_____
Frequent ear infections	☐ Yes	☐ No	Explain_____
Problems with ears or hearing	☐ Yes	☐ No	Explain_____
Nasal allergies	☐ Yes	☐ No	Explain_____
Problems with eyes or vision	☐ Yes	☐ No	Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes	☐ No	Explain_____
Any heart problem or heart murmur	☐ Yes	☐ No	Explain_____
Anemia or bleeding problem	☐ Yes	☐ No	Explain_____
Blood transfusion	☐ Yes	☐ No	Explain_____
Frequent abdominal pain	☐ Yes	☐ No	Explain_____
Constipation requiring doctor visits	☐ Yes	☐ No	Explain_____
Bladder or kidney infection	☐ Yes	☐ No	Explain_____
Bed-wetting (after age 5)	☐ Yes	☐ No	Explain_____
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain_____
(For girls) Are there any problems with her periods?	☐ Yes	☐ No	Explain_____
Any chronic or recurrent skin problem (acne, eczema, etc.)	☐ Yes	☐ No	Explain_____
Frequent headaches	☐ Yes	☐ No	Explain_____
Convulsions or other neurologic problems	☐ Yes	☐ No	Explain_____
Diabetes	☐ Yes	☐ No	Explain_____
Thyroid or other endocrine problem	☐ Yes	☐ No	Explain_____
Any other significant problem	☐ Yes	☐ No	Explain_____
Use of alcohol or drugs	☐ Yes	☐ No	Explain_____