



*"Bringing Old-Fashioned Medicine Back Home"*  
Initial History Questionnaire

**Child's Name** \_\_\_\_\_

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**Date of Birth** \_\_\_\_\_

Male  Female

**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 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 living in the 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 weeks gestation? \_\_\_\_\_

Did mother have any illness or problem with her pregnancy?

Yes  No Explain \_\_\_\_\_

\_\_\_\_\_

Was the delivery  Vaginal?  Cesarean?

If cesarean, why? \_\_\_\_\_

\_\_\_\_\_

Did your baby have any problems right after birth?

Yes  No Explain \_\_\_\_\_

\_\_\_\_\_

During pregnancy, did mother: *(Circle all that apply)*

Smoke  Drink Alcohol  Use Drugs or Medication

What \_\_\_\_\_ When \_\_\_\_\_

Was initial feeding  Breast?  Bottle?

Did your baby go home with mother from the hospital?

Yes  No Explain \_\_\_\_\_

\_\_\_\_\_

**General *(Circle Yes or No)***

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

**Development *(Circle Yes or No)***

Are you concerned about your child's physical development?	Yes	No	Explain _____
Are you concerned about your child's mental or emotional development?	Yes	No	Explain _____
Are concerned about your child's attention span?	Yes	No	Explain _____

If your child is in school:

Name of School \_\_\_\_\_ Current Grade \_\_\_\_\_

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 (Circle Yes or No)**

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 50yrs)	Yes	No	Who _____	Comments _____
High blood pressure (before 50yrs)	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 50 yrs)	Yes	No	Who _____	Comments _____
Bed-wetting (after 10 yrs)	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 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Patient Medical History (Circle Yes or No)**

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

Chickenpox	Yes	No	When _____
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 5yrs)	Yes	No	Explain _____
(For girls) Has she started her menstrual periods?	Yes	No	Explain _____
(For girls) Are there 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 problem	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 _____

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