"Bringing Old-Fashioned Medicine Back Home"

Initial History Questionnaire

Child's Name ______________________

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 ______________

____

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

Smoke Drink Alcohol Use Drugs or Medication

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 *(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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Form Completed By **Date Completed**

Relationship to Patient