WaverlyHealth
CENTER

Pediatric Initial History Questionnaire

____________________ Patient Representative Signature/Relationship Date	____________________ Name
____________________ Medical Provider Signature Date	____________________ Birthdate Age M F

Household

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

Name	Relationship to Child	Birthdate	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 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
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 ______________________

Is your child allergic to any medicine or drugs? ____ Yes ____ No Explain ______________________

CURRENT MEDICATIONS

☐ I take no medications, vitamins, minerals, or herbs.

Medication/Vitamins/Minerals/Herbs	Dose/Strength	#/Amount You Take	How Often it is Taken

Pharmacy Used:

Please list additional medications on the back page. Check here if you have listed additional medications: ☐

PAST HISTORY

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

ADHD/anxiety/mood problems/depression Yes ___ No ___ Explain ________________________________
Developmental delay Yes ___ No ___ Explain ________________________________
Dental decay Yes ___ No ___ Explain ________________________________
History of family violence Yes ___ No ___ Explain ________________________________
Sexually transmitted infections Yes ___ No ___ Explain ________________________________
Pregnancy Yes ___ No ___ Explain ________________________________
(For girls) Problems with her periods Explain ________________________________
Has had first period: Yes ___ No ___ Age of first period _______________
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 5 years old) 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 problems (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 ________________________________

Patient Name: ________________________________
DOB: ____

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 50 years old) Yes ___ No ___ Who_____________ Comments_______________________

High blood pressure (before 50 years old) 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 years old) Yes ___ No ___ Who_____________ Comments_______________________

Bed-wetting (after 10 years old) 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_______________________

Does your family have any beliefs, religious or cultural practices that your healthcare team should be aware of in order to provide the best care for your child? ___ Yes ___ No

Additional family history____

Patient Name: __________________________________
DOB: ____