WAVERLY HEALTH CENTER

Pediatric Initial History Questionnaire

_____ ☐ M ☐ F _____ _____
Name of Child Birthdate Age

_____ _____ _____ _____
Date Patient Representative Signature/Relationship Date Medical Provider Signature

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	Explanation/Comments
Birth weight:	
Was the delivery ☐ Vaginal ☐ Cesarean If cesarean, explain why?	
Was the baby born at term? ☐ Early? ☐ Late?	
If early, how many weeks' gestation?	
Did your baby have any problems right after birth? ☐ Yes ☐ No	
Was initial feeding ☐ Breast ☐ Bottle	
Did mother have any illness or problem with her pregnancy? ☐ Yes ☐ No	
Did your baby go home with mother from the hospital? ☐ Yes ☐ No	
During pregnancy, did mother: Smoke ☐ Yes ☐ No Drink Alcohol ☐ Yes ☐ No Use drugs or medications ☐ Yes ☐ No	What: When:

GENERAL	Yes	No	Explanation/Comments
Do you consider your child to be in good health?			
Does your child have any serious illness or medical condition?			
Has your child had serious injuries or accidents?			
Has your child had any surgery?			
Has your child ever been hospitalized?			
Is your child allergic to any medicine or drugs?			

CURRENT MEDICATIONS - ☐ I take no medications, vitamins, minerals or herbs.

Medication/Vitamins/Minerals/Herbs	Dose/Strength	# / Amount You Take	How often is it 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 had:	Yes	No	Explanation/Comments
ADHD/anxiety/mood problems/depression			
Developmental delay			
Dental decay			
History of family violence			
Sexually transmitted infections			
Pregnancy			
(For girls) Are there problems with her periods? Has had first period: ☐ Yes ☐ No Age of first period: _____			
Chickenpox			
Frequent ear infections			
Problems with ears or hearing			
Nasal allergies			
Problems with eyes or vision			
Asthma, bronchitis, bronchiolitis, or pneumonia			
Any heart problem or heart murmur			
Anemia or bleeding problem			
Blood transfusion			
Frequent abdominal pain			
Constipation requiring doctor visits			
Bladder or kidney infection			
Bed-wetting (after 5 years old)			

Patient Name: _____ Birthdate: _____

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PAST HISTORY - continued

Does your child have or has he/she had:	Yes	No	Explanation/Comments
Chronic or recurrent skin problems (acne, eczema, etc.)			
Frequent headaches			
Convulsions or other neurologic problems			
Diabetes			
Thyroid or other endocrine problem			
Any other significant problem			
Use of alcohol or drugs			

Have any family members had the following:	Yes	No	Explanation/Comments
Deafness			
Nasal allergies			
Asthma			
Tuberculosis			
Heart disease (before 50 years old)			
High blood pressure (before 50 years old)			
High cholesterol			
Anemia			
Bleeding disorder			
Liver disease			
Kidney disease			
Diabetes (before 50 years old)			
Bed-wetting (after 10 years old)			
Epilepsy or convulsions			
Alcohol abuse			
Drug abuse			
Mental illness			
Intellectual disability/Mental retardation			
Immune problems, HIV or AIDS			

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: _____ Birthdate: _____