SAINT JOSEPH
Regional Medical Center
PHYSICIAN NETWORK

INITIAL HISTORY QUESTIONNAIRE

Name: _____

ID Number: _____ Birth Date: _____ Age: _____

Form completed by: _____ Date completed: _____

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 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 house, 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 medicines or drugs?

☐ Yes ☐ No Explain _____

Development

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 you concerned about your child's 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? _____

Please continue on next page

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 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 _____
Bedwetting (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 _____

Additional family history _____

_____

_____

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

Chicken pox	☐ 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 _____
Bedwetting (after 5 years old)	☐ Yes	☐ No	Explain _____
(For girls) Has she started her menstrual period?	☐ Yes	☐ No	When _____
(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 _____

Please continue on next page

PREVENTATIVE SCREENING QUESTIONNAIRE

Name:	Date of Birth:

Date:	/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /		/ /	
TUBERCULOSIS SCREENING	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Was your child born in, or has he/she lived in a foreign country?																				
Has your child been exposed to anyone with either active Tuberculosis, or past infection with Tuberculosis?																				
Is your child exposed to anyone who is HIV positive, substance abuser or a resident of a correctional facility?																				

LEAD SCREEN	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Does your child now live, or has he/she ever lived in a house or apartment built before 1978?																				
Is any adult in the family exposed to lead in their occupation or hobby?																				
Has anyone in the home been diagnosed with lead poisoning?																				
Do you have any reason to think your child may have been exposed to lead?																				

CHOLESTEROL SCREEN	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Is there a family history of males under 50 years of age or females under 60 years of age with high cholesterol, sudden death, heart attack, diabetes or strokes?																				

FLUORIDE SCREEN	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
Do you have non-fluoridated well water?																				