Peachtree Pediatrics, PLLC
Initial History Questionnaire

If possible attach a copy of your child's immunization record and return with this form at your appointment.

Child's Name _____ Birth Date:_____ Age:_____

Form Completed by: _____ Date Completed:_____

Household- Please list all those living in the child's home

Name	**Relationship to child**	**Age**	**Health Problems**

Are there any siblings not listed? If so, please list their names, ages and where they live?
_____

What is the child's living situation if not with both biological parents?

☐Lives with adoptive parents ☐Joint Custody ☐Single Custody ☐Lives with foster family

If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?
_____
_____

Birth History

Birth weight_____lbs. _____oz.

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

Date of Adoption (is applicable)_____

Was the delivery? ☐Vaginal? ☐Cesarean?

If cesarean, why? _____
_____

Did baby have any problems right after birth?

☐Yes ☐No Explain_____
_____

Use drugs or medications? ☐Yes ☐No What? and When?
_____
_____

Was initial feeding ☐Breast? ☐Bottle?
Did baby go home with mother from hospital?
☐Yes ☐No Explain_____

General (if applicable)

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 been hospitalized? ☐Yes ☐ No Explain _____
Is your child allergic to any medications or drugs? ☐Yes ☐No Explain_____
Does your child take any medications on a regular basis? ☐Yes ☐No Explain _____

Development (is applicable)

Name of school (or daycare) and grade in school _____
How is his/her behavior in school? _____
Has he/ she repeated a grade in school? _____
How is he/she doing in academic subjects? _____
Is he/ she is special or resource classes? _____
Are you concerned with your child's physical development? ☐Yes ☐No Explain _____
Are you concerned with your child's emotional or mental development? ☐Yes ☐No Explain_____
_____
Are you concerned about your child's attention span? ☐Yes ☐No Explain _____

Family History- have and family members had the following ☐Unknown

Deafness ☐Yes ☐No Who_____ Comments_____
Allergies (food or environment) ☐Yes ☐No Who_____ Comments_____
Asthma ☐Yes ☐No Who_____ Comments_____
Tuberculosis ☐Yes ☐No Who_____ Comments_____
Heart disease or sudden death (before age 50) ☐Yes ☐No Who_____ Comments_____
High Blood Pressure (before 50 years old) ☐Yes ☐No Who_____ Comments_____
High Cholesterol ☐Yes ☐No Who_____ Comments_____
Anemia/ Bleeding disorder ☐Yes ☐No Who_____ Comments_____
Liver/ Kidney disease ☐Yes ☐No Who_____ Comments_____
Diabetes (before 50 years old) ☐Yes ☐No Who_____ Comments_____
Epilepsy or convulsions ☐Yes ☐No Who_____ Comments_____
Alcohol/ Drug abuse ☐Yes ☐No Who_____ Comments_____
Mental illness/ depression ☐Yes ☐No Who_____ Comments_____
Mental retardation ☐Yes ☐No Who_____ Comments_____
Immune problems, HIV or AIDS ☐Yes ☐No Who_____ Comments_____
Cancer ☐Yes ☐No Who_____ Comments_____
Gastrointestinal problems ☐Yes ☐No Who_____ Comments_____

Home Environment- Please check all that are in the household where the child resides:

☐ Smokers ☐Smoke Detectors ☐Guns/ Firearms
☐ Carbon monoxide detectors ☐Pets _____(type)

Past History (if applicable)- Does your child have or has he/ she ever had:

Chickenpox	☐Yes ☐No When_____
Frequent ear infections / hearing loss	☐Yes ☐No Explain_____
Allergies (food or environment)	☐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_____
HIV	☐Yes ☐No Explain_____
Organ transplant	☐Yes ☐No Explain_____
Malignancy/ bone marrow transplant	☐Yes ☐No Explain_____
Chemotherapy	☐Yes ☐No Explain_____
Frequent abdominal pain/ constipation	☐Yes ☐No Explain_____
Bladder or kidney infection	☐Yes ☐No Explain_____
Congenital/cataracts/retinoblastoma	☐Yes ☐No Explain_____
Metabolic/ Genetic disorders	☐Yes ☐No Explain_____
Cancer	☐Yes ☐No Explain_____
Kidney disease or urologic malformations	☐Yes ☐No Explain_____
Bed-wetting (after 5 years old)	☐Yes ☐No Explain_____
Sleep problems; snoring	☐Yes ☐No Explain_____
Any chronic or recurrent skin problem	☐Yes ☐No Explain_____
Frequent headaches	☐Yes ☐No Explain _____
Obesity	☐Yes ☐No Explain_____
High Blood pressure	☐Yes ☐No Explain_____
Convulsions or other neurological problems	☐Yes ☐No Explain_____
Diabetes	☐Yes ☐No Explain_____
Thyroid or other endocrine problems	☐Yes ☐No Explain_____
History of serious injuries/fractures/concussions	☐Yes ☐No Explain_____
Tobacco use	☐Yes ☐No Explain_____
ADHD/anxiety/mood problems/depression	☐Yes ☐No Explain_____
Dental decay	☐Yes ☐No Explain_____
History of family violence	☐Yes ☐No Explain_____

Sexually transmitted infections ☐Yes ☐No Explain_____

Alcohol/ Drug use ☐Yes ☐No Explain_____

Any other significant problems ☐Yes ☐No Explain_____

(For Girls) Problems with their periods ☐Yes ☐No Explain_____

Had had first period ☐Yes ☐No Age of first period:_____