

Ambler Pediatrics

Initial History Questionnaire

(circle one)

Patient Name _____

Date of Birth _____ M F

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: _____

Household

Please list all those living in the child's home

First and last name	Relationship to child	Date of Birth

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(s) not in the home? _____

If there are any pets in the home, please indicate below: _____

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? _____

Are there any physical limitations with any of the following?

	Patient	Parent/Guardian	Please explain:
Vision	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Physical	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Learning	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Emotional	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spiritual/Cultural	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Primary Spoken Language:	<input type="checkbox"/> English	<input type="checkbox"/> English <input type="checkbox"/> Other: _____	OVER PLEASE>>>

Family History		Past History	
Have any family members had the following:		Does your child have, or has he/she ever had:	
·Deafness	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Chickenpox	<input type="checkbox"/> Yes <input type="checkbox"/> No When _____
·Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Frequent ear infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Problems with ears or hearing	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Heart disease (before 50 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Problems with eyes or vision	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·High blood pressure (before 50 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·High cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Any heart problem or heart murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Anemia or bleeding problem	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Bleeding disorder		·Frequent abdominal pain	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Liver disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Constipation requiring doctor visit	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Kidney disease	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Bladder or kidney infection	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Diabetes (before 50 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Bed-wetting (after 5 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Bed-wetting (after 10 yrs old)	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·(Girls)- Started menstrual periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No When _____
·Epilepsy or convulsions	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·(Girls) Problems with periods?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Alcohol abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Chronic or recurrent skin problems (acne, eczema, etc.)?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Cigarette smokers	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Frequent headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Drug abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Convulsions or other neurological problem	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Mental illness	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
·Mental retardation	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Thyroid or other endocrine problem	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
·Immune problems, HIV or AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No Who _____	·Use of alcohol or drugs	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
		·ADHD/learning disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
		·Other significant problem	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____

Additional history _____

Questionnaire completed by: _____ Relationship to patient: _____

(please print)

By signing below, I certify that the above information I have provided is true and accurate to the best of my knowledge.

X _____

Today's Date _____