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 or been hospitalized?	**□ Yes □ No Explain: _____**
Is your child on any medications (include prescription, over-the-counter, homeopathic)?	**□ Yes □ No List: _____**

Household

Please list all those living in the child's home

First and last name	Relationship to child	Date of Birth

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

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? _____
_____

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	**□Yes □No**	**□Yes □No**	
Hearing	**□Yes □No**	**□Yes □No**	
Physical	**□Yes □No**	**□Yes □No**	
Learning	**□Yes □No**	**□Yes □No**	
Emotional	**□Yes □No**	**□Yes □No**	
Spiritual/Cultural	**□Yes □No**	**□Yes □No**	
Primary Spoken Language:	**□English**	**□English □Other:_____**	**OVER PLEASE>>>**

Family History

Have any family members had the following:

·Deafness	□ Yes □ No Who _____
·Nasal allergies	□ Yes □ No Who _____
·Asthma	□ Yes □ No Who _____
·Tuberculosis	□ Yes □ No Who _____
·Heart disease (before 50 yrs old)	□ Yes □ No Who _____
·High blood pressure (before 50 yrs old)	□ Yes □ No Who _____
·High cholesterol	□ Yes □ No Who _____
·Anemia	□ Yes □ No Who _____
·Bleeding disorder	
·Liver disease	□ Yes □ No Who _____
·Kidney disease	□ Yes □ No Who _____
·Diabetes (before 50 yrs old)	□ Yes □ No Who _____
·Bed-wetting (after 10 yrs old)	□ Yes □ No Who _____
·Epilepsy or convulsions	□ Yes □ No Who _____
·Alcohol abuse	□ Yes □ No Who _____
·Cigarette smokers	□ Yes □ No Who _____
·Drug abuse	□ Yes □ No Who _____
·Mental illness	□ Yes □ No Who _____
·Mental retardation	□ Yes □ No Who _____
·Immune problems, HIV or AIDS	□ Yes □ No Who _____

Past History

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

·Chickenpox	□ Yes □ No When_____
·Frequent ear infections	□ Yes □ No
·Problems with ears or hearing	□ Yes □ No Explain _____
·Allergies (nasal, allergic to medications or other)	□ 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 _____
·Frequent abdominal pain	□ Yes □ No
·Constipation requiring doctor visit	□ Yes □ No
·Bladder or kidney infection	□ Yes □ No Explain _____
·Bed-wetting (after 5 yrs old)	□ Yes □ No
·(Girls)- Started menstrual periods?	□ Yes □ No When _____
· (Girls) Problems w/periods?	□ Yes □ No Explain _____
·Chronic or recurrent skin problems (acne, eczema, etc.)?	□ Yes □ No Explain _____
·Frequent headaches	□ Yes □ No
·Convulsions or other neurological problem	□ Yes □ No Explain _____
·Diabetes	□ Yes □ No
·Thyroid or other endocrine problem	□ Yes □ No Explain _____
·Use of alcohol or drugs	□ Yes □ No Explain _____
·ADHD/learning disabilities	□ Yes □ No Explain _____
·Other significant problem	□ Yes □ 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***_____