Frederick Pediatric Associates

Initial History Questionnaire

Patient Name: _____ DOB:_____ Sex: ☐ M ☐ F
Previous Doctor/Birth Hospital:_____ Last Visit: _____
Dentist Name: _____ Last Visit: _____
Are the patient's immunizations up to date? ☐ Yes ☐ No Do you have the immunization record? ☐ Yes ☐ No

Family and Social Profile

Mother's Information	Father/Partner's Information
Full Name: _____	Full Name: _____
DOB: _____ Age: _____	DOB: _____ Age: _____
SS#: _____	SS#: _____
Contact Phone: _____	Contact Phone: _____
Occupation: _____	Occupation: _____
Lives with Patient? ☐ Yes ☐ No	Lives with Patient? ☐ Yes ☐ No
Are Parents:: ☐ Married ☐ Separated ☐ Divorced ☐ Never Together ☐ Living Together ☐ Other: _____	Child Care: ☐ Parents ☐ Relative ☐ Daycare
House built before 1978? ☐ Yes ☐ No	Sibling Names DOB Lives with patient?
Is your water from a well? ☐ Yes ☐ No	_____
Are there guns in the home? ☐ Yes ☐ No	_____
Are there pets in the home? ☐ Yes ☐ No	_____
Any foreign travel in the past 5 years? ☐ Yes ☐ No	_____
Are there any smokers in the household? ☐ Yes ☐ No	_____
If yes, do they smoke inside the home or outside? ☐ Inside ☐ Outside	_____

Pregnancy and Birth ☐ Don't know birth history

Is the patient yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: _____
Baby's Birth Weight: _____ Type of Delivery: ☐ Vaginal ☐ Cesarean
Mother's Age at Birth: _____ -if cesarean, why?_____
Was baby on time? ☐ Yes ☐ No If no, how early or late was the baby? _____
Any prenatal/neonatal complications? ☐No ☐Yes, explain:_____
Was a NICU stay required? ☐No ☐Yes, explain: _____
Check if mother had any of the following complications during pregnancy or delivery:
☐ Tobacco use ☐ Alcohol use ☐ Marijuana/Drug use ☐ Gestational Diabetes
☐ Bleeding ☐ Fever ☐ High Blood Pressure ☐ Other: _____
Medications during pregnancy: _____
Was the patient ☐Breastfeed (how long:_____) ☐ Formula fed (which formula: _____)

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Patient History

Check if your child has had any of the following:

□ ADD/ADHD	□ Allergies (environmental)	□ Anemia	□ Autism
□ Asthma	□ Constipation	□ Depression/Anxiety	□ Diabetes
□ Diarrhea/GI Problems	□ Eczema	□ Frequent Ear Infections	□ Hearing Loss
□ Heart Disease	□ Pneumonia	□ Reflux	□ Seizures
□ Urinary Problems	□ Cancer: _____	□ Chicken Pox: Date: _____	

□ Other:_____

Has the patient had any hospitalizations or surgeries? □ Yes □ No
If yes, please list date, name of hospital, injury or illness: _____
_____

At what age did your child sit alone? _____
At what age did your child walk alone? _____
At what age did your child say words? _____

Do you have any concerns? Check applicable.
□ Speech □ School
□ Development □ Behavior

Allergies (Food or Medication)

Allergy	Reaction

Current Medications (OTC and Prescription)

Name	Dose

Biological Family Medical History: Have any family members had the following?

□ AIDS/HIV/Immune:	Who:_____	Comments:_____
□ Alcohol/Drug Abuse:	Who:_____	Comments:_____
□ Allergies:	Who:_____	Comments:_____
□ Anemia:	Who:_____	Comments:_____
□ Asthma:	Who:_____	Comments:_____
□ Bed Wetting (after age 10):	Who:_____	Comments:_____
□ Bleeding Disorder:	Who:_____	Comments:_____
□ Cancer:	Who:_____	Comments:_____
□ Childhood Hearing Loss:	Who:_____	Comments:_____
□ Depression/Mental Illness:	Who:_____	Comments:_____
□ Dental Decay:	Who:_____	Comments:_____
□ Developmental Disability:	Who:_____	Comments:_____
□ Diabetes (before age 55):	Who:_____	Comments:_____
□ Heart Disease (before age 55):	Who:_____	Comments:_____
□ High Blood Pressure:	Who:_____	Comments:_____
□ High Cholesterol:	Who:_____	Comments:_____
□ Kidney/Liver Disease:	Who:_____	Comments:_____
□ Migraines:	Who:_____	Comments:_____
□ Obesity**:**	Who:_____	Comments:_____
□ Seizures:	Who:_____	Comments:_____
□ Thyroid Disease:	Who:_____	Comments:_____
□ Tuberculosis:	Who:_____	Comments:_____

□ Other: _____
_____

□ NONE OF THE ABOVE
□ BIOLOGICAL FAMILY HISTORY UNKNOWN