BON SECOURS MEDICAL GROUP

Initial History Questionnaire

FORM COMPLETED BY	DATE COMPLETED	Name	ID NUMBER	BIRTH DATE	AGE	☐ M ☐ F

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 home, 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____________________

Is your child taking any medications currently? ☐ Yes ☐ No List Medications____________________

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?____________________

Family History

Have any family members had the following:

Condition	Yes	No	Who	Comments
Deafness	☐ Yes	☐ No	Who______	Comments______
Nasal allergies	☐ Yes	☐ No	Who______	Comments______
Asthma	☐ Yes	☐ No	Who______	Comments______
Eczema	☐ 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______
Bed-wetting (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______
Cancer and type	☐ Yes	☐ No	Who______	Comments______

Additional family history ______________________________

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Past History

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

Condition	Yes	No	Details
Chickenpox	☐ 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______
Bed-wetting (after 5 years old)	☐ Yes	☐ No	Explain______
(For girls) Has she started her menstrual periods?	☐ Yes	☐ No	Explain______
(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			
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______

Does the patient have any medical issues related to the following systems?

System	Yes/No	Detail	Treatment
Weight (Eating)			
Height (Growing)			
Eyes			
Ears			
Stomach/Bowels/Vomiting			
Mouth/Dental/Vomiting			
Heart			
Kidney/Urinary			
Skin/Rashes			
Allergies			
Breathing			
Hormonal Issues			
Blood/Bleeding Disorders			
Depression/Nervous Disorders			
Others Not Listed			

Dental Health History

YES NO

☐ ☐ Does your child have a dental condition about which you are especially concerned?

If yes, please explain____________________

☐ ☐ Is this your child's first visit to the dentist? If not, date of last dental care?____________________

☐ ☐ Has your child ever received injuries to the head, jaw, mouth or teeth?

If yes, describe____________________

☐ ☐ Does your child have a toothache?

☐ ☐ Was your child a thumb/finger sucker? Age discontinued?____________________

☐ ☐ Did your child use a pacifier? Age discontinued?____________________

☐ ☐ Was your child bottle-fed? Age discontinued?____________________

☐ ☐ Was you child breast-fed? Age discontinued?____________________

☐ ☐ Is your child a mouth breather?

☐ ☐ Does your child grind or clench his/her teeth?

☐ ☐ Do you child's gums bleed?

☐ ☐ Is your child presently taking a flouride supplement? If so, what?____________________

☐ ☐ What is your water source? Public System__________ Private Well__________ Reverse Osmosis System__________

☐ ☐ How often are your child's teeth brushed per day?__________ By who?__________ What type of toothpaste?__________

I certify that I have read and understand the above questions.

Signature of Parent or Legal Guardian ____________________ Relationship to patient ____________________ Witness ____________________ Date ____________________