Patient's Name: _____**M**____**F**____ **DOB:** _____

Form Completed By: _____ **Date Completed:** _____

Beatrice Community Hospital and Health Center Clinics
Pediatric Initial Health History Questionnaire

Please complete the following information which will be kept in the patient's medical record.

Household

Please list all those living in the child's home.

Name	Relationship to Patient	Birth Date	Health Problems

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

Birth History

◯ Don't know birth history ◯ Adopted

Birth weight: _____ Was the baby born at term? _____ OR _____weeks

Were there any prenatal or neonatal complications? ◯ Yes ◯ No

Explain: _____

Was a NICU stay required? ◯ Yes ◯ No Explain: _____

_____

During pregnancy, did mother: Use tobacco ◯ Yes ◯ No

Drink alcohol ◯ Yes ◯ No Use prenatal vitamins ◯ Yes ◯ No

Use drugs or medications ◯ Yes ◯ No What:_____When:_____

Was the delivery ◯ Vaginal ◯ Cesarean If cesarean, why?

_____.

Was initial feeding ◯ Formula ◯ Breast Milk

How long breastfed?_____.

General

DK = don't know

Do you consider your child to be in good health? ◯ Yes ◯ No ◯ DK Explain: _____

_____

Has your child had any surgery? ◯ Yes ◯ No ◯ DK Dates & procedure:_____

_____

Has your child ever been hospitalized? ◯ Yes ◯ No ◯ DK Dates & Condition:_____

_____

Is your child allergic to medicine or drugs? ◯ Yes ◯ No ◯ DK Explain:_____

_____

Biological Family History

DK = don't know

Have any family members had the following?

Childhood hearing loss	◯ Yes ◯ No ◯ DK	Comments_____
Nasal Allergies	◯ Yes ◯ No ◯ DK	Comments_____
Asthma	◯ Yes ◯ No ◯ DK	Comments_____
Tuberculosis	◯ Yes ◯ No ◯ DK	Comments_____
Heart Disease (before 55 years old)	◯ Yes ◯ No ◯ DK	Comments_____
High Cholesterol	◯ Yes ◯ No ◯ DK	Comments_____
Anemia	◯ Yes ◯ No ◯ DK	Comments_____
Bleeding Disorder	◯ Yes ◯ No ◯ DK	Comments_____
Dental Decay	◯ Yes ◯ No ◯ DK	Comments_____

(Over)

Cancer (before 55 years old)	◯ Yes ◯ No ◯ DK	Comments_____
Liver Disease	◯ Yes ◯ No ◯ DK	Comments_____
Kidney Disease	◯ Yes ◯ No ◯ DK	Comments_____
Diabetes (before 55 years old)	◯ Yes ◯ No ◯ DK	Comments_____
Bed-wetting (after 10 years old)	◯ Yes ◯ No ◯ DK	Comments_____
Obesity	◯ Yes ◯ No ◯ DK	Comments_____
Epilepsy or Convulsions	◯ Yes ◯ No ◯ DK	Comments_____
Alcohol Abuse	◯ Yes ◯ No ◯ DK	Comments_____
Drug Abuse	◯ Yes ◯ No ◯ DK	Comments_____
Mental Illness/Deprssion	◯ Yes ◯ No ◯ DK	Comments_____
Developmental Disability	◯ Yes ◯ No ◯ DK	Comments_____
Immune Problems, HIV, or AIDS	◯ Yes ◯ No ◯ DK	Comments_____
Tobacco Use	◯ Yes ◯ No ◯ DK	Comments_____

Additional Family History:_____

Patient's Past History

DK = don't know

Does your child have, or has your child ever had:

Problems with ears or hearing	◯ Yes ◯ No ◯ DK	Comments_____
Nasal allergies	◯ Yes ◯ No ◯ DK	Comments_____
Problems with eyes or vision	◯ Yes ◯ No ◯ DK	Comments_____
Asthma, bronchitis, bronchiolitis,	◯ Yes ◯ No ◯ DK	Comments_____
or pneumonia	◯ Yes ◯ No ◯ DK	Comments_____
Constipation requiring doctor visits	◯ Yes ◯ No ◯ DK	Comments_____
Recurrent urinary tract infections	◯ Yes ◯ No ◯ DK	Comments_____
Bed-wetting (after 5 years old)	◯ Yes ◯ No ◯ DK	Comments_____
Sleep problems; snoring	◯ Yes ◯ No ◯ DK	Comments_____
Chronic or recurrent skin problems	◯ Yes ◯ No ◯ DK	Comments_____
Frequent headaches	◯ Yes ◯ No ◯ DK	Comments_____
Convulsions/Other neurologic problems	◯ Yes ◯ No ◯ DK	Comments_____
Obesity	◯ Yes ◯ No ◯ DK	Comments_____
History of fractures/concussions	◯ Yes ◯ No ◯ DK	Comments_____
Use of alcohol, drugs, or tobacco	◯ Yes ◯ No ◯ DK	Comments_____
ADHD/Anxiety/Depression	◯ Yes ◯ No ◯ DK	Comments_____
Devlopemental delay	◯ Yes ◯ No ◯ DK	Comments_____
Dental decay	◯ Yes ◯ No ◯ DK	Comments_____
Females: Problems with periods	◯ Yes ◯ No ◯ DK	Comments_____

Age of 1st period:_____

Any other significant problem(s):_____

_____

_____

_____

_____

Patient's Name: _____M____F____ DOB: _____

Form Completed By: _____ Date Completed: _____