Little Steps Pediatrics, LLC

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PEDIATRICS

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INITIAL HISTORY QUESTIONNAIRE

NAME

ID NUMBER

FORM COMPLETED BY DATE COMPLETED BIRTH DATE AGE ☐ M ☐

Household

Please list all those in the child's home.

Name	Relationship to Child	Birth Date	Health Problems

Are there siblings not listed? If no, please list their names, ages, and where they live.

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
If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

Birth History ☐ Don't know birth history

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 Drugs or Medications? ☐ Yes ☐ No ☐ Used Prenatal Vitamins
What _____ When_____

Was the Delivery ☐ Vaginal ☐ Cesarean If cesarean, why?

Was Initial Feeding ☐ Formula ☐ Breast Milk How Long breastfed?
Did your baby go home with mother from the hospital?
☐ Yes ☐ No Explain:

General DK = Don't Know

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

Does your child have any serious illnesses or medical conditions? ☐ Yes ☐ No ☐ DK Explain:

Has your child had any surgery? ☐ Yes ☐ No ☐ DK Explain:

Has your child ever been hospitalized? ☐ Yes ☐ No ☐ DK Explain:

Is your child allergic to medicines or drugs? ☐ Yes ☐ No ☐ DK Explain:

Do you feel you family has enough to eat? ☐ Yes ☐ No ☐ DK Explain:

Medication List

Biological Family History DK = Don't Know

Have any family members had the following?

					Comments:
Childhood hearing loss	☐ Yes	☐ No	☐ DK	Who:	Comments:
Nasal allergies	☐ Yes	☐ No	☐ DK	Who:	Comments:
Asthma	☐ Yes	☐ No	☐ DK	Who:	Comments:
Tuberculosis	☐ Yes	☐ No	☐ DK	Who:	Comments:
Heart disease (before 55 years old)	☐ Yes	☐ No	☐ DK	Who:	Comments:
High cholestorl/takes cholesterol medication	☐ Yes	☐ No	☐ DK	Who:	Comments:
Anemia	☐ Yes	☐ No	☐ DK	Who:	Comments:
Bleeding disorder	☐ Yes	☐ No	☐ DK	Who:	Comments:
Dental decay	☐ Yes	☐ No	☐ DK	Who:	Comments:
Cancer (before 55 years old)	☐ Yes	☐ No	☐ DK	Who:	Comments:

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Biological Family History DK = Don't Know (Continued from front side)

Liver disease	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Kidney disease	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Diabetes (before 55 years old)	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Bed wetting (after 10 years old)	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Obesity	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Epilepsy or convulsions	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Alcohol abuse	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Drug abuse	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Mental illness / depression	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Developmental disability	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Immune problems, HIV, or AIDS	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____
Tobacco use	☐ Yes ☐ No ☐ DK Who:_____	Comments:_____

Additional family history_____

Past History DK = Don't Know

Does your child have, or has your child ever had

Chickenpox	☐ Yes ☐ No ☐ DK When: _____
Frequent ear infections	☐ Yes ☐ No ☐ DK Explain: _____
Problems with ears or hearing	☐ Yes ☐ No ☐ DK Explain: _____
Nasal allergies	☐ Yes ☐ No ☐ DK Explain: _____
Problems with eyes or vision	☐ Yes ☐ No ☐ DK Explain: _____
Asthma, bronchitis, bronchiolitis, or pneumonia	☐ Yes ☐ No ☐ DK Explain: _____
Any heart problem or heart murmur	☐ Yes ☐ No ☐ DK Explain: _____
Anemia or bleeding problem	☐ Yes ☐ No ☐ DK Explain: _____
Blood transfusion	☐ Yes ☐ No ☐ DK Explain: _____
HIV	☐ Yes ☐ No ☐ DK Explain: _____
Organ transplant	☐ Yes ☐ No ☐ DK Explain: _____
Malignancy/bone marrow transplant	☐ Yes ☐ No ☐ DK Explain: _____
Chemotherapy	☐ Yes ☐ No ☐ DK Explain: _____
Frequent abdominal pain	☐ Yes ☐ No ☐ DK Explain: _____
Constipation requiring doctor visits	☐ Yes ☐ No ☐ DK Explain: _____
Recurrent urinary tract infections and problems	☐ Yes ☐ No ☐ DK Explain: _____
Congenital cataracts/retinoblastoma	☐ Yes ☐ No ☐ DK Explain: _____
Metabolic/genetic disorders	☐ Yes ☐ No ☐ DK Explain: _____
Cancer	☐ Yes ☐ No ☐ DK Explain: _____
Kidney disease or urologic malformations	☐ Yes ☐ No ☐ DK Explain: _____
Bed-wetting (after 5 years old)	☐ Yes ☐ No ☐ DK Explain: _____
Sleep problems, snoring	☐ Yes ☐ No ☐ DK Explain: _____
Chronic or recurrent skin problems (eg, acne, eczema)	☐ Yes ☐ No ☐ DK Explain: _____
Frequent headaches	☐ Yes ☐ No ☐ DK Explain: _____
Convulsions or other neurologic problems	☐ Yes ☐ No ☐ DK Explain: _____
Obesity	☐ Yes ☐ No ☐ DK Explain: _____
Diabetes	☐ Yes ☐ No ☐ DK Explain: _____
Thyroid or other endocrine problems	☐ Yes ☐ No ☐ DK Explain: _____
High blood pressure	☐ Yes ☐ No ☐ DK Explain: _____
History of serious injuries/fractures/concussions	☐ Yes ☐ No ☐ DK Explain: _____
Use of alcohol or drugs	☐ Yes ☐ No ☐ DK Explain: _____
Tobacco use	☐ Yes ☐ No ☐ DK Explain: _____
ADHD/anxiety/mood problems/depression	☐ Yes ☐ No ☐ DK Explain: _____
Developmental delay	☐ Yes ☐ No ☐ DK Explain: _____
Dental decay	☐ Yes ☐ No ☐ DK Explain: _____
History or family violence	☐ Yes ☐ No ☐ DK Explain: _____
Sexually transmitted infections	☐ Yes ☐ No ☐ DK Explain: _____
Pregnancy	☐ Yes ☐ No ☐ DK Explain: _____
(For girls) Problems with her periods	☐ Yes ☐ No ☐ DK Explain: _____

Has had first period ☐ Yes ☐ No Age of first period_____

Any other significant problems_____