

# Paula Watts-White, M.D., Inc.

Pediatrics & Adolescent Medicine

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|                                      |      |            |     |
|--------------------------------------|------|------------|-----|
| <b>Initial History Questionnaire</b> |      | Name       |     |
| Completed by                         | Date | Birth date | Age |

## HOUSEHOLD

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

| Name | Relationship to child | Birth date | Health problems | Occupation |
|------|-----------------------|------------|-----------------|------------|
|      |                       |            |                 |            |
|      |                       |            |                 |            |
|      |                       |            |                 |            |
|      |                       |            |                 |            |

Are there any 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 of both parents are not living in the home, how often does he/she see the parent(s) not in the home?

\_\_\_\_\_

## BIRTH HISTORY

Birth Weight: \_\_\_\_\_

Was the delivery Vaginal? Cesarean? If Cesarean, why? \_\_\_\_\_

Was the baby born at term? \_\_\_\_\_ Early? \_\_\_\_\_ Late? \_\_\_\_\_

If early, how many weeks gestation? \_\_\_\_\_

Did your baby have any problems after birth? If yes, explain \_\_\_\_\_

Did mother have any illness or problem with her pregnancy?

## GENERAL

Do you consider your child to be in good health?  
Yes No Explain \_\_\_\_\_

Has your child had serious injuries or accidents?  
Yes No Explain \_\_\_\_\_

Does your child have any serious illness or medical condition?  
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 \_\_\_\_\_

**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 \_\_\_\_\_

**FAMILY HISTORY**

Have any family members had the following:

Deafness: Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

Asthma: Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

Tuberculosis Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

Heart Disease (before 50) Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

**PAST HISTORY**

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

Chickenpox  
Yes No When \_\_\_\_\_

Problems with ears or hearing  
Yes No Explain \_\_\_\_\_

Nasal Allergies  
Yes No Explain \_\_\_\_\_

Asthma, bronchitis, bronchiolitis, or pneumonia  
Yes No Explain \_\_\_\_\_

Pharmacy of preference:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list the medications your child is taking:  
\_\_\_\_\_

If your child is in school:

How is his/her behavior in school?  
\_\_\_\_\_

How is he/she doing in academic subjects?  
\_\_\_\_\_

School name: \_\_\_\_\_ Grade: \_\_\_\_\_  
Teacher: \_\_\_\_\_

High blood pressure (before 50) Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

High Cholesterol Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

Mental Illness Yes No Who \_\_\_\_\_  
Comments \_\_\_\_\_

Additional Family History

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any heart problem or heart murmur  
Yes No Explain \_\_\_\_\_

(For girls) Has she started her menstrual periods?  
Yes No When? \_\_\_\_\_

Are there any problems with her periods? \_\_\_\_\_

Any other significant problem?  
Yes No Explain \_\_\_\_\_