WEST CHESTER PEDIATRICS, INC. **Initial Patient History Questionnaire**

PATIENT _____ _____ **DOB** ____/____/____ **Age** _____ **M** **F**
FIRST NAME LAST NAME

Form Completed by _____ Relationship _____ Date Completed ____/____/____
please print

Transferred care from _____ Records Obtained? ❒ Yes ❒ No

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, 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 initial feeding ❒ Breast? ❒ Bottle?

Did your baby have any problems right after birth? ❒ Yes ❒ No

If yes, explain _____

At Term? _____ Early? _____ Late? _____ If early, how many weeks' gestation? _____

Was the delivery: ❒ Vaginal? ❒ Cesarean? If Cesarean, why? _____

Obstetrician's Name _____

Did your baby go home with mother from the hospital ? ❒ Yes ❒ No

If no, explain _____

Did mother have any illness or problem with her pregnancy ❒ Yes ❒ No

If yes, explain

_____

_____

During pregnancy, did mother:

Smoke? ❒ Yes ❒ No

Drink Alcohol? ❒ Yes ❒ No

Use drugs or medications? ❒ Yes ❒ No

If yes, what _____

When _____

GENERAL

Do you consider your child to be in good health? ❒ Yes ❒ No Explain _____

Are your child's immunizations up to date? ❒ 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 _____

Does anyone smoke in the home? ❒ 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 _____

If your child is in school:

How is his/her behavior in school? _____

Has he/she failed or repeated a grade in school? ❒ Yes ❒ No Explain _____

How is he/she doing in academic subjects? _____

Is he/she in special or resource classes? ❒ Yes ❒ No Explain _____

FAMILY HISTORY

Have any family members had the following:

Deafness ❒ Yes ❒ No Who _____ Comments _____
Nasal allergies ❒ Yes ❒ No Who _____ Comments _____
Asthma ❒ 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 _____
Environmental tobacco smoke ❒ Yes ❒ No Who _____ Comments _____
House built prior to 1970 ❒ Yes ❒ No Who _____ Comments _____
Additional family history _____

PATIENT'S PAST HISTORY

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

Chickenpox ❒ Yes ❒ No Who _____ Comments _____
Frequent ear infections ❒ Yes ❒ No Who _____ Comments _____
Problems with ears or hearing ❒ Yes ❒ No Who _____ Comments _____
Nasal allergies ❒ Yes ❒ No Who _____ Comments _____
Problems with eyes or vision ❒ Yes ❒ No Who _____ Comments _____
Asthma, bronchitis, bronchiolitis, or pneumonia ❒ Yes ❒ No Who _____ Comments _____
Any heart problem or heart murmur ❒ Yes ❒ No Who _____ Comments _____
Anemia or bleeding problem ❒ Yes ❒ No Who _____ Comments _____
Blood transfusion ❒ Yes ❒ No Who _____ Comments _____
Frequent abdominal pain ❒ Yes ❒ No Who _____ Comments _____
Constipation requiring doctor visits ❒ Yes ❒ No Who _____ Comments _____
Bladder or kidney infection ❒ Yes ❒ No Who _____ Comments _____
Bed-wetting (after 5 years old) ❒ Yes ❒ No Who _____ Comments _____
(For Girls) Has she started her menstrual period? ❒ Yes ❒ No Who _____ Comments _____
(For Girls) Are there problems with her periods? ❒ Yes ❒ No Who _____ Comments _____
Chronic or recurrent skin problems (acne, eczema, etc.) ❒ Yes ❒ No Who _____ Comments _____
Frequent headaches ❒ Yes ❒ No Who _____ Comments _____
Convulsion or other neurologic problem ❒ Yes ❒ No Who _____ Comments _____
Diabetes ❒ Yes ❒ No Who _____ Comments _____
Thyroid or other endocrine problem ❒ Yes ❒ No Who _____ Comments _____
Use of alcohol or drugs ❒ Yes ❒ No Who _____ Comments _____
Use of tobacco ❒ Yes ❒ No Who _____ Comments _____
Is he/she sexually active? ❒ Yes ❒ No Who _____ Comments _____
Any other significant problem? ❒ Yes ❒ No Who _____ Comments _____