Casas Pediatrics 1925 W. Orange Grove Rd, Ste 109, Tucson, AZ 85704 MRN# Date

Initial History Questionnaire

Name: Last, First

FORM COMPLETED BY	DATE COMPLETED	BIRTH DATE	AGE	SEX
				M F

Household

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

Name	Relationship to child	Birth date	Health Problems	Occupation

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? _____

_____

What languages are spoken in the home?
☐ English ☐ Spanish ☐ Other _____

Birth History

Did mother have any illness or problem with the pregnancy? ☐ Yes ☐ No Explain _____

During the pregnancy did mother use medications, drugs, smoke or drink alcohol? ☐ Yes ☐ No Explain _____

Was the delivery ☐ Vaginal? ☐ C-section?

Was the baby ☐ Term? ☐ Early? Gestational Age? _____ weeks

What was the baby's birth weight? _____ lbs _____ oz.

Did your baby have any problems right after birth? ☐ Yes ☐ No Explain _____

What was the initial feeding? ☐ Breast ☐ Formula

Did your baby pass the hearing screen? ☐ Yes ☐ No

Did your baby get the Hepatitis B vaccine? ☐ Yes ☐ No

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 _____

Are your child's immunizations up-to-date? ☐ Yes ☐ No ☐ I don't know

List all your child's current medications:

Name_____ Dose _____ Frequency _____

Name_____ Dose _____ Frequency _____

Name_____ Dose _____ Frequency _____

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 _____

If your child is in school:

What grades does your child get? ☐ Low ☐ Average ☐ High

Does your child have behavior problems in school? ☐ Yes ☐ No Explain _____

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

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

MRN#
Date

Name _____ Birth Date _____

Patient Past History

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

Chickenpox	☐ Yes ☐ No	When	_____
Frequent ear infections	☐ Yes ☐ No	Explain	_____
Problems with ears or hearing	☐ Yes ☐ No	Explain	_____
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, bleeding problem or 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	_____
Sprains or fractures	☐ Yes ☐ No	Explain	_____
Frequent headaches	☐ Yes ☐ No	Explain	_____
Convulsions or other neurologic problem	☐ Yes ☐ No	Explain	_____
Concussion or head trauma	☐ Yes ☐ No	Explain	_____
Diabetes	☐ Yes ☐ No	Explain	_____
Thyroid or other endocrine problem	☐ Yes ☐ No	Explain	_____
Obesity or Eating Disorder	☐ Yes ☐ No	Explain	_____
Use of alcohol or drugs	☐ Yes ☐ No	Explain	_____
Any other significant problem	☐ 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 _____
Sudden Death	☐ 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 / 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 _____
Epilepsy or convulsions	☐ Yes ☐ No	Who	_____	Comments _____
Alcohol or 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 _____

Additional family history _____

_____