BON SECOURS MEDICAL GROUP

Initial History Questionnaire

Name			
ID NUMBER			
FORM COMPLETED BY / DATE COMPLETED	BIRTH DATE	AGE	☐ M ☐ F

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 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?

Birth History

Birth weight

Was the baby born at term? Early? Late?

If early, how many weeks' gestation?

Did mother have any illness or problem with her pregnancy?

☐ Yes ☐ No Explain

During pregnancy, did mother:

Smoke ☐ Yes ☐ No Drink alcohol ☐ Yes ☐ No

Use drugs or medications ☐ Yes ☐ No

What When

Was the delivery ☐ Vaginal? ☐ Cesarean?

If cesarean, why?

Did your baby have any problems right after birth?

☐ Yes ☐ No Explain

Was initial feeding ☐ Breast? ☐ Bottle?

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
Is your child taking any medications currently?	☐ Yes	☐ No	List Medications

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?

How is he/she doing in academic subjects?

Is he/she in special or resource classes?

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_____	
Eczema	☐ 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_____	
Cancer and type	☐ Yes ☐ No	Who_____	Comments_____	

Additional family history _____

_____

_____

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_____	
Nasal 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 or bleeding problem	☐ Yes ☐ No	Explain_____	
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_____	
Frequent headaches			
Convulsions or other neurologic problem	☐ Yes ☐ No	Explain_____	
Diabetes	☐ Yes ☐ No	Explain_____	
Thyroid or other endocrine problem	☐ Yes ☐ No	Explain_____	
Any other significant problem	☐ Yes ☐ No	Explain_____	
Use of alcohol or drugs	☐ Yes ☐ No	Explain_____	

Does the patient have any medical issues related to the following systems?

System	Yes/No	Detail	Treatment
Weight (Eating)			
Height (Growing)			
Eyes			
Ears			
Stomach/Bowels/Vomiting			
Mouth/Dental/Vomiting			
Heart			
Kidney/Urinary			
Skin/Rashes			
Allergies			
Breathing			
Hormonal Issues			
Blood/Bleeding Disorders			
Depression/Nervous Disorders			
Others Not Listed			

Dental Health History

YES NO

☐ ☐ Does your child have a dental condition about which you are especially concerned?

If yes, please explain_____

☐ ☐ Is this your child's first visit to the dentist? If not, date of last dental care?_____

☐ ☐ Has your child ever received injuries to the head, jaw, mouth or teeth?

If yes, describe_____

☐ ☐ Does your child have a toothache?

☐ ☐ Was your child a thumb/finger sucker? Age discontinued?_____

☐ ☐ Did your child use a pacifier? Age discontinued?_____

☐ ☐ Was your child bottle-fed? Age discontinued?_____

☐ ☐ Was you child breast-fed? Age discontinued?_____

☐ ☐ Is your child a mouth breather?

☐ ☐ Does your child grind or clench his/her teeth?

☐ ☐ Do you child's gums bleed?

☐ ☐ Is your child presently taking a flouride supplement? If so, what?_____

☐ ☐ What is your water source? Public System_____ Private Well_____ Reverse Osmosis System_____

☐ ☐ How often are your child's teeth brushed per day?_____ By who?_____ What type of toothpaste?_____

I certify that I have read and understand the above questions.

Signature of Parent or Legal Guardian	Relationship to patient	Witness	Date