

**Yale Health Plan – Pediatric Department
Initial History Questionnaire**

If possible attach a copy of your child's immunization record and return with this form at your appointment.

Child's Name		Date of Birth	Age
Address		Form Completed By	Date Completed
Home Phone	Cell Phone		Work Phone

Household - please list all those living in the child's home

Name	Relationship to child	Age	Occupation	Health Problems

Are there siblings not listed? If so, please list their names and ages and where they live.

If parents are not living together or if child does not live with parents, what is the child's custody status?

Birth History

Birth weight _____ lbs. _____ oz.
 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? And When?

Date of adoption (if applicable) _____
 Was the delivery Vaginal? Cesarean?
 If cesarean, why? _____

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

 Was initial feeding Breast? Bottle?
 Did baby go home with mother from the hospital?
 Yes No Explain _____

General (if applicable)

Do you consider your child to be in good health?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Does your child have any serious illness or medical condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child had serious injuries or accidents?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child had any surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Has your child been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Is your child allergic to any medicine or drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Does your child take any medications on a regular basis?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____

Development (if applicable)

Name of school (or daycare) and grade in school _____
 How is his/her behavior in school? _____
 Has he/she repeated a grade in school? _____
 How is he/she doing in academic subjects? _____
 Is he/she in special or resource classes? _____

Are you concerned about your child's physical development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Are you concerned about your child's mental or emotional development?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____
Are you concerned about your child's attention span?	<input type="checkbox"/> Yes <input type="checkbox"/> No Explain _____

Clinician Signature _____

OVER--->

Family History – have any family members had the following: Unknown

- Deafness Yes No Who _____ Comments _____
- Allergies (food or environmental) Yes No Who _____ Comments _____
- Asthma Yes No Who _____ Comments _____
- Tuberculosis Yes No Who _____ Comments _____
- Heart disease or sudden death (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/Kidney disease Yes No Who _____ Comments _____
- Diabetes (before 50 years old) Yes No Who _____ Comments _____
- Epilepsy or convulsions Yes No Who _____ Comments _____
- Alcohol/Drug abuse Yes No Who _____ Comments _____
- Mental illness/depression Yes No Who _____ Comments _____
- Mental retardation Yes No Who _____ Comments _____
- Immune problems, HIV or AIDS Yes No Who _____ Comments _____
- Cancer Yes No Who _____ Comments _____
- Gastrointestinal problems Yes No Who _____ Comments _____

Past History (if applicable) – Does your child have or has he/she ever had:

- Chickenpox Yes No When _____
- Frequent ear infections/hearing loss Yes No Explain _____
- Allergies (food or environmental) 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 _____
- Frequent abdominal pain/constipation 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 period Yes No When and list any problems _____
- Any chronic or recurrent skin problem Yes No Explain _____
- Frequent headaches Yes No Explain _____
- Convulsions or other neurological problems Yes No Explain _____
- Diabetes Yes No Explain _____
- Thyroid or other endocrine problems Yes No Explain _____
- Alcohol/Drug use Yes No Explain _____
- Any other significant problems Yes No Explain _____

Home Environment – Please check all that are in the household where the child resides:

- Smokers
 - Smoke detectors
 - Pets _____
 - Guns/Firearms
 - Carbon monoxide detectors
 -
- (type)