Initial History Questionnaire

Welcome to North Raleigh Pediatrics! Thank you for entrusting the care of your children to our clinic. To best care for your child we need to get to know them, so please take the time to fully complete this questionnaire. If you need extra space for the "Comments" sections, please use the space at the bottom of the page. Thank you for your time.

Today's date:______________

Child's Full Name:____________________________________ DOB:___________________

Preferred Name:___________________ [ ] Male [ ] Female

Form Completed by:________________relationship___________ Chart#:___________________

SOCIAL HISTORY Please list those living in the child's home:

Name	Relationship	Birth date	Job or School	Health Problems

Biological Parents: [ ] Married [ ] Divorced [ ] Single [ ] Separated [ ]Remarried

If both parents are not living together, who has custody?

	No	Yes	Comments
Are there any siblings not listed above?			
Does your child go to daycare?			where:
Does your child go to school?			where:
Does anyone in your family smoke (even outside)?			who
Does your family have any pets?			type:
Do you have smoke alarms in your house?			
Does your family routinely use seatbelts/carseats?			

BIRTH HISTORY of your child

Born: on time - late – premature(how early? gestational age_____weeks) **At what hospital?**

Birth weight: lbs ozs	No	Yes	Comments on "Yes"
Did mom have any problems with pregnancy?			type:
Was your baby born by Cesarean section?			why:
Did your baby have any problems after birth?			type:
Did baby stay in the hospital after mom went home?			why:

PAST MEDICAL HISTORY	No	Yes	Comments on "Yes"
Has your child had any surgery?			when : why:
Has your child ever been hospitalized?			when : why:
Does you child have any chronic or serious medical conditions?			type:
Has your child had any serious accidents or injuries?			type:
Does your child have any developmental problems?			type:
Is your child allergic to any medications?			meds: type reaction:
Did your child miss or skip any vaccines?			which ones:
Does your child take any medications on a regular basis?			med & dose:
Any over the counter medications on a regular basis?			med & dose:

Extra Comments:

____

____

____

____

____

____

Name:____ DOB: _______________

FAMILY HISTORY Any family members (parents, siblings, grandparents, aunts or uncles only) have these?							
	No	**Yes**	**Relation/Type Problem**		**No**	**Yes**	**Relation/Type**
Eye problems				Immune Problems			
Deafness				Tuberculosis			
Allergies				Bleeding Disorders			
Asthma				Liver disease			
Anemia				Kidney disease			
Heart Disease				Drug abuse			
High Cholesterol				Seizures			
Mental Illness				Cancer			
Diabetes				Active Smoker			
Thyroid disease				Birth Defect			

REVIEW OF SYSTEMS Has your child had any problems with or do you have concerns with any of the following:							
	No	**Yes**	**Comments on "Yes"**		**No**	**Yes**	**Comments on "Yes"**
Vision or Eyes				Bedwetting/soiling			
Many ear infections				Skin problems			
Hearing problems				Seizures			
Nasal problems				Many headaches			
Heart, murmurs				Diabetes			
Wheezing, Asthma				Thyroid problems			
Pneumonia				Menstrual problems			
Abdominal pain				Anemia			
Constipation				Bleeding problems			
Liver problems				Chickenpox			
High blood pressure				Developmental probs			
Joint pain/swelling				Attention problems			
Broken bones				Sleep problems			
Many sore throats				Illicit drug use			
Bladder/kidney probs				Any other concerns			

Extra Comments: ____

____

____

Thank you for your time filling out this form. Please sign below stating to the best of your knowledge the above information is correct.

____________________________________ ____________

Signature of parent/guardian date

For clinic use only (provider comments)

I have reviewed the above information with the parent/guardian.

____________________________________ ____________

Provider signature date