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 (both front and back). If you need extra space for the "Comments" sections, please use the space at the bottom of the back page. Thank you for your time.

Child's Full Name: _____ Today's Date: _____
DOB: _____ Preferred Name: _____ [ ] Male [ ] Female
Form Completed by: _____ Relationship _____

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?
[ ] Patient Adopted
Patient primarily resides with: [ ] Parents [ ] Mother [ ] Father [ ] Grandparents [ ] Relative [ ] Other

	Yes	Comments:
Are there any siblings not listed above?		
Does your child go to daycare?		Where?
Does your family have pets?		Type?
Does your family routinely use seatbelts?		
Guns in home?		Locked Cabinet: [ ] Yes [ ] No
What is your water source? [ ] private well [ ] community well [ ] city		
Tobacco Exposure: [ ] none [ ] occasional [ ] daily [ ] caregiver smokes outside [ ] patient smokes		

Family History:
Any family member (**Parents, siblings, grandparents, aunts or uncles only**) have these?

	Yes	Who? Type?		Yes	Who? Type?
Eye Problems			Immune Problems		
Deafness			Tuberculosis		
Allergies			Intestinal Disorder		
Asthma			Liver Disease		
Anemia			Kidney Disease		
Heart Disease			Drug Abuse		
High Cholesterol			Seizures		
Mental Illness			Cancer		
Diabetes			Birth Defects		
Thyroid Disease			High Blood Pressure		
Gastroesophageal Reflux			Bleeding/Clotting Disorders		

Birth History of your child (if child is under 1 year old)
At What hospital was your child delivered?
Born: [ ] on time [ ] late [ ] premature; If premature, How early? Gestational age _____ weeks
Birth weight: _____ lbs _____ oz

	Yes	Comments
Did Mom have any problems in pregnancy?		
Was your baby born by Cesarean Section?		Why?
Did your baby have any problems at birth?		Type?
Was your child's hospital stay extended?		Why?

Please fill out other side

Continued

Current Medical Status	Yes	Comments
Is your child allergic to any medications?		Med? Reaction?
Does your child take any (prescription or over-the-counter) medications on a regular basis?		Med & dose?
Did your child miss or skip any vaccines?		Which ones?
Has your child had any serious accidents or injuries?		Type?
Does your child have any developmental problems?		Type?
Has your child had any surgery?		When? Why?
Has your child ever been hospitalized?		When? Why?

Past Medical History	Has your child had any problems with any of the following?				
	Yes	Comments		Yes	Comments
Vision or Eyes			Skin Problems		
Many Ear Infections			Seizures		
Hearing Problems			Headaches		
Nasal Problems			Diabetes		
Heart Murmurs			Thyroid Problems		
Wheezing, Asthma			Menstrual Problems		
Pneumonia			Anemia		
Chronic Abdominal Pain			Bleeding Problems		
Constipation			Chicken Pox		
Liver Problems			Attention Problems		
High Blood Pressure			Sleep Problems		
Joint pain/swelling			Illicit drug use		
Broken bones			Genetic Conditions		
Bladder/kidney Infections			Cancer		
Bedwetting/Soiling					

Other: _____

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

_____ _____

Parent/Guardian Signature Date

For Clinic use only (Provider Comments)

_____

_____

_____

_____

Providers Signature