FAMILY MEDICAL CENTER

Dr. Jyotin K. Patel, M.D., Inc.

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Initial History Questionnaire

PATIENT NAME		RESPONSIBLE PERSON CONTACT	TELEPHONE
BIRTH DATE	AGE ☐ M ☐ F	FORM COMPLETED BY	DATE COMPLETED

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 _____

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 _____
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 _____
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 _____

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 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	When	_____
(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	☐ Yes ☐ No	Explain	_____
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	_____