

Initial History Questionnaire

Form Completed By: _____

Name: _____

Initial Date Completed: _____

ID Number: _____

Date(s) Updated: _____

Birth Date: _____

Age: _____

Sex: M F

GENERAL

- Do you consider your child to be in good health? Yes No Don't know Explain: _____
- Does your child have any special health care needs? Yes No Don't know Explain: _____
- Has your child ever been hospitalized? Yes No Don't know Explain: _____
- Is your child allergic to medicine or drugs? Yes No Don't know Explain: _____

SOCIAL HISTORY

Please list all those living in the child's home.

| Name | Relationship to Child | Birth Date/Age |
|------|-----------------------|----------------|
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Please list other siblings not living in the home.

| Name | Birth Date/Age | Where are they living? |
|------|----------------|------------------------|
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Does the child live with both biological parents? Yes No

If no, what is the child's current living situation?

Single-parent custody Joint custody Adoptive family

Other family members: _____ Foster care

How often does the child have visitation with parent(s) not living in the home?

Instructions for health care professionals on how to use this form can be found in the *User Guide and Instructions for Toolkit Implementation* at <https://toolkits.solutions.aap.org/bright-futures>.

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American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN®



BIRTH HISTORY

Birth weight: _____

Full-term Preterm _____ weeks Post-term _____ weeks

Delivery: Vaginal Cesarean Reason: _____

Any complications during birth or after birth? No Yes

Explain: _____

Did the baby need to go to the NICU (neonatal intensive care unit)?

No Yes Explain: _____

During pregnancy, did the mother:

Take prenatal vitamins? Yes No Unknown

Smoke or use e-cigarettes? Yes No Unknown

Drink alcohol? Yes No Unknown

Use marijuana? Yes No Unknown

Use illicit drugs? Yes No Unknown

Take other medications? Yes No Unknown

If yes, please list: _____

Blood type:

Mother: _____ Unknown

Baby: _____ Unknown

Mother's lab results:

Hepatitis B Pos Neg Unknown

HIV Pos Neg Unknown

Group B streptococcus (GBS) Pos Neg Unknown

After birth, did the baby get:

Vitamin K shot? Yes No Unknown

Erythromycin eye ointment? Yes No Unknown

Hepatitis B shot? Yes No Unknown

How was the baby fed? Bottle formula Bottle breast milk

Breastfed How long was baby breastfed? _____

Did baby go home with biological mother from hospital after birth? Yes

No Explain: _____

The recommendations in this questionnaire do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate. Original questionnaire included as part of the *Bright Futures Tool and Resource Kit*, 2nd Edition. The American Academy of Pediatrics (AAP) does not review or endorse any modifications made to this questionnaire and in no event shall the AAP be liable for any such changes.

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HE0564

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY

Has your child ever had any of the following problems? DK = Don't know

| Condition | DK | No | Yes | Details |
|--|----|----|-----|---------|
| Eye problems, cataracts, or retinoblastoma | | | | |
| Vision impairment or concerns | | | | |
| Nasal allergies (dust, pets, or environmental) | | | | |
| Frequent ear infections | | | | |
| Hearing loss or concerns | | | | |
| Multiple cavities or problems with teeth | | | | |
| Frequent colds or sore throats | | | | |
| Asthma, wheezing, or breathing problems | | | | |
| Bronchitis, bronchiolitis, or pneumonia | | | | |
| Heart murmur or other heart problems | | | | |
| High blood pressure | | | | |
| Frequent stomach pain | | | | |
| Constipation needing medical treatment | | | | |
| Food allergies or intolerance (eg, milk, gluten) | | | | |
| Feeding issues or underweight | | | | |
| Overweight or obesity | | | | |
| Urinary tract infections | | | | |
| Bed-wetting (after 5 years old) | | | | |
| Kidney, ureter, or bladder problems | | | | |
| Serious injuries or fractures | | | | |
| Bone, joint, or muscle problems | | | | |
| Frequent headaches or dizziness | | | | |
| Concussion or head injury | | | | |
| Convulsions, seizures, or neurological issues | | | | |
| Sleep problems or snoring | | | | |
| Skin rashes, eczema, or hives | | | | |
| Acne | | | | |
| Thyroid or other endocrine problems | | | | |
| Diabetes | | | | |
| Metabolic/genetic disorders | | | | |
| Anemia or bleeding problems | | | | |
| Cancer or chemotherapy | | | | |
| Bone marrow or organ transplant | | | | |

Initial History Questionnaire

Name: _____

PAST MEDICAL HISTORY *(continued)*

Has your child ever had any of the following problems? DK = Don't know

| Condition | DK | No | Yes | Details |
|--|----|----|-----|---------|
| Blood transfusion | | | | |
| HIV or AIDS | | | | |
| Chickenpox or zoster (shingles) | | | | |
| Developmental delays (speech or motor) | | | | |
| School problems or learning difficulties | | | | |
| ADHD or behavioral concerns | | | | |
| Anxiety, depression, or mood problems | | | | |
| Tobacco, alcohol, or drug use | | | | |
| Exposure to family violence | | | | |
| Pregnancy or miscarriage | | | | |
| Sexually transmitted infections | | | | |
| Females: issues with periods | | | | |
| Age of first period: | | | | |

Other medical problems (Please list.)

SURGICAL HISTORY

Has your child ever had surgery? No Yes If yes, please provide details below.

| Surgery/Procedure | Date of Surgery/Child's Age | Where Completed | Details |
|-------------------|-----------------------------|-----------------|---------|
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Other surgical/procedural problems (Please list.)

Initial History Questionnaire

Name: _____

FAMILY HISTORY

Have any of your child's parents, grandparents, aunts, uncles, brothers, or sisters ever had any of the following conditions? DK = Don't know

| Condition | DK | No | Yes | Who? | Details |
|--------------------------------------|----|----|-----|------|---------|
| Anemia or bleeding problems | | | | | |
| Asthma | | | | | |
| Allergies | | | | | |
| Alcohol use problems | | | | | |
| Bed-wetting (after age 10 years) | | | | | |
| Cancer (before age 55 years) | | | | | |
| Childhood hearing loss | | | | | |
| Dental decay or multiple cavities | | | | | |
| Depression or anxiety | | | | | |
| Developmental disability | | | | | |
| Diabetes | | | | | |
| Heart attack (myocardial infarction) | | | | | |
| Heart disease (before age 55 years) | | | | | |
| High blood pressure | | | | | |
| High cholesterol | | | | | |
| HIV or AIDS | | | | | |
| Kidney disease | | | | | |
| Liver disease | | | | | |
| Mental health conditions | | | | | |
| Obesity | | | | | |
| Seizures or epilepsy | | | | | |
| Stroke | | | | | |
| Substance use problems | | | | | |
| Sudden death (before age 50 years) | | | | | |
| Thyroid or other endocrine disease | | | | | |
| Tobacco use problems | | | | | |
| Tuberculosis | | | | | |
| Vision or eye problems | | | | | |

Other medical problems (Please list.)

PRINT NAME.

SIGNATURE

Provider 1

Provider 2

Consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 4th Edition