

Pediatrics at Whitlock, P.C.

707 Whitlock Ave., Ste D30
Marietta, GA 30064
770-499-8909; 770-499-8911 (F)

INITIAL HISTORY QUESTIONNAIRE

(please print)

Name of Patient: _____ D.O.B. _____ M ___ F ___

Form Completed by: _____

Relationship to Patient: _____

Date Completed: _____

Medications: include all prescription, nonprescription, maintenance & as needed meds

Name _____	Dose _____	How often ? _____
Name _____	Dose _____	How often ? _____
Name _____	Dose _____	How often ? _____
Name _____	Dose _____	How often ? _____

Allergies: please specify type, reaction (hives, swelling, etc.), severity (mild, moderate or severe) & interventions (benadryl, epi pen, etc.)

- To Medications - _____
- To Food - _____
- Insects, Animals, Other - _____

Immunizations: Up-to-date? Yes ___ No ___ PLEASE BRING OR FAX RECORDS.

Birth History:

Born where _____	Birth Weight _____
Type of Delivery _____ emergency? _____	Discharge Weight _____
Forceps or Vacuum? yes ___ no ___	Length _____
Gestational Age _____	Head Circumference _____
Hep B given at birth? Yes ___ No ___	PKU done ≥ 48hrs of age? Yes ___ No ___
Initial Feeding, breast or bottle? _____	
Mother's Pregnancy Health:	
Abnormal Labs/Tests? _____	
(Yes/No) High Blood Pressure ___ Diabetes ___ If so, did this condition exist prior to pregnancy ___	
Smoked ___ Drank Alcohol ___ Drugs ___ If so, type & frequency _____	
Birth Complications _____	
Problems during the hospital course _____	

Past Medical History: check anything that your child has had in the past & give details at the end...

ADD/ADHD _____	Convulsions or Seizures _____	High Blood Pressure _____
Frequent Ear Infections _____	Other Neurologic Problem _____	Kidney, Bladder Problem _____
Hearing Problems _____	Thyroid Disorder _____	Recurring Sinus Infection _____
Nasal Allergies _____	Diabetes Mellitus _____	History of Abuse _____
Eye or Vision Problem _____	Other Endocrine Problem _____	Sleeping Problems _____
Heart Problem, Murmur _____	Alcohol or Drug Use _____	Speech Problems _____
Anemia. Bleeding Prob. _____	History of Wheezing, _____	Temper Problems _____
Blood Transfusion(s) _____	use of Inhaler or Asthma _____	Hx. Of Thumb sucking _____
Frequent Abdominal Pain _____	Dental Problems _____	Toilet training problem _____
Constipation requiring a _____	Development Problems _____	Other Chronic Problem _____
doctor's visit _____	Discipline Problems _____	_____

INITIAL HISTORY QUESTIONNAIRE, Page 2

Bedwetting after 5yrs _____ Eating Problems _____
Recurring Skin Problem _____ Emotional Problems _____
Frequent Headaches _____ Handicaps or Disability _____

Adolescent Female History:

Onset of menses _____ LMP _____ Problems _____
If ≥ 16 yrs, have you been taught a self breast exam? ___ Do you perform it monthly? ___
Have you been to see a Gynecologist? ___ Name of Provider _____
History of Pregnancies _____

History of Childhood Illnesses: No ___ Yes ___ *If so, list the date of illness below...*

Chicken pox _____ Measles _____ Mumps _____ Rubella _____ Polio _____

History of Hospitalizations: No ___ Yes ___ *If yes, please give details.*

Date _____ Location _____ Reason _____
Date _____ Location _____ Reason _____
Date _____ Location _____ Reason _____
Date _____ Location _____ Reason _____

History of Surgeries: No ___ Yes ___ *If yes, please give details.*

Date _____ Surgeon _____ Location _____
Procedure Performed _____
Date _____ Surgeon _____ Location _____
Procedure Performed _____
Date _____ Surgeon _____ Location _____
Procedure Performed _____

History of Injuries: No ___ Yes ___ *If yes, please give details.*

Location/Type of Injury _____ Circumstances _____
Date _____ Treatment _____
Location/Type of Injury _____ Circumstances _____
Date _____ Treatment _____
Location/Type of Injury _____ Circumstances _____
Date _____ Treatment _____

Prior Screening Tests: (Y/N and results)

Anemia Screening _____
Lead Screening _____
Tuberculosis _____
Hearing _____
Vision _____
Cholesterol _____
Prior Workup by Specialist _____
Prior Allergy Skin Tests _____
Psychological Tests _____

Family Medical History indicate who in relationship to child has the following problems...

Unremarkable (Please select this if all answers below are no) _____

Gastrointestinal Problems _____ High Cholesterol _____
Deafness _____ Anemia _____
Nasal Allergies _____ Liver Disease _____
Asthma _____ Kidney Disease _____
Bronchitis _____ Bedwetting >10yrs old _____

INITIAL HISTORY QUESTIONNAIRE, Page 3

Wheezing _____ Epilepsy, Seizures or Convulsions _____
Tuberculosis _____ Mental Illness or Retardation _____
Heart Disease <50yrs old _____ Alcohol Abuse _____
Heart Attack <50yrs old _____ Drug Abuse _____
Blood Pressure <50yrs old _____ HIV or Aids _____
Migraines _____ Other Immune Problems _____
Diabetes <50yrs old _____ Skin Conditions _____
Cancer; list type _____

Social History

General:

Parent Information: Married ___ Separated ___ Divorced ___ Single Parent ___
Legal Guardian _____

Patient lives with _____

Home Occupants _____

Primary Caretaker: Mother ___ Father ___ Other _____

Pets: Yes ___ No ___; If so, what type & how many? _____

Smoking: Yes ___ No ___; If so, what type & where? _____

Alcohol Use: No ___ Yes ___; If yes, what type & how often? _____

Drug Use: No ___ Yes ___; If yes, what type & how often? _____

Guns in the household: Yes ___ No ___; If yes, are the guns locked & separate from ammunition? ___

All Ages:

Child-parent Interaction _____

Infants & Children <6yrs old:

Reads to children: Yes ___ No ___

Childcare: Home with parents ___ Home with Babysitter ___ Babysitter in private home ___

Family Daycare ___ Daycare Center (list name) _____

Childproofing appropriate for age: Yes ___ No ___ Need Information ___

Children >6yrs old:

Name of School _____ Grade _____

GPA &/or Grades on Last Report Card _____

Favorite Subject _____ Least Favorite Subject _____

Problems: _____

Child Care after school _____

Adolescent Female History:

Onset of menses _____ LMP _____ Problems _____

If ≥16yrs, have you been taught a self breast exam? ___ Do you perform it monthly? ___

Have you been to see a Gynecologist? ___ Name of Provider _____

History of Pregnancies _____

Development:

Reached milestones at a normal age: Yes ___ No ___ Not sure ___

Delayed? Yes ___ No ___; If yes, in what area? _____

Has your child been evaluated? Yes ___ No ___; If so, by whom? _____

Is your child receiving therapy? No ___ Yes ___

If yes, what type? Speech ___ Occupational Therapy ___ Physical Therapy ___ Other _____

If yes, where? _____