Cohen Children's Northwell Health | Concorde Pediatrics

General Pediatrics

Initial History Questionnaire

Form Completed By _____ Date Completed _____

Patient Name _____ Date of Birth _____

Preferred Pharmacy Name, Address and Phone Number _____

Household

Please note, if you (the patient) are 18+ years, these questions pertain to you

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

Name	Relationship to Child	Birth Date

Parent 1: _____
Name

Occupation: _____

Highest Level of Education: ☐Grade School ☐High School ☐Bachelor's Degree ☐Post Graduate Degree

Parent 2: _____
Name

Occupation: _____

Highest Level of Education: ☐Grade School ☐High School ☐Bachelor's Degree ☐Post Graduate Degree

◆Who does the child live with?

☐ Lives with biological parents ☐ Lives with adoptive parents ☐ Joint Custody ☐ Single Custody ☐ Lives with foster family ☐Other_____

◆Are there siblings not listed? If so, please list their names, ages and where they live.

_____

◆If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History

☐ **Don't know birth history**

Please note, if you (the patient) are 18+ years, these questions pertain to you

Birth Weight_____ Birth Length_____

Was the baby born at term? _____ or _____weeks

Were there any prenatal or neonatal complications?

☐Yes ☐No Explain_____

Was a NICU stay required? ☐Yes ☐No

Explain_____

During pregnancy, did mother:

◆Use tobacco? ☑Yes ☐No

◆Drink alcohol? ☐Yes ☐No

◆Use drugs/medications? ☐Yes ☐No

◆Take prenatal vitamins? ☐Yes ☐No

Was the delivery ☐Vaginal ☐Cesarean

If cesarean, why? _____

Was initial feeding ☐Formula ☐Breast milk

How long breastfed?_____

Did child go home with mother from the hospital?

☐Yes ☐No Explain_____

_____

Safety and Lifestyle

☐ **Don't know**

Please note, if you (the patient) are 18+ years, these questions pertain to you

◆Are there any guns in the child's home?

☐Yes ☐No

◆If yes, are appropriate safety measures in place?

☐Yes ☐No

◆Does the child use a car seat or seat belt at all times?

☐Yes ☐No

◆Is the hot water temperature less than 125°F?

☐Yes ☐No

◆Does anyone smoke in your home and/or car?

☐Yes ☐No

◆Are there smoke detectors at home?

☐Yes ☐No

◆Are there carbon monoxide detectors at home?

☐Yes ☐No

◆Does the child's home have exposure to lead paint?

☐Yes ☐No

◆Are there any pets at home?

☐Yes ☐No If yes, type?_____

◆How many hours per day does your child watch television/play video games? _____ Get exercise?_____

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General ☐Don't know

*Please note, if you (the patient) are 18+ years, these questions pertain to you

◆Do you consider your child to be in good health?
☐Yes ☐No
Explain_____

◆Does your child have any serious illnesses or medical conditions?
☐Yes ☐No
Explain_____

◆Has your child had any surgery?
☐Yes ☐No
Explain_____

◆Has your child ever been hospitalized?
☐Yes ☐No
Explain_____

◆Does your child take any daily medications? (including prescriptions, over the counter medications & vitamins)
☐Yes ☐No
Explain_____

◆Has your child ever had an allergic reaction to any medicine or food?
☐Yes ☐No
Explain_____

◆Is your child receiving or has previously received any services? (e.g. Physical/Occupational/Speech Therapy)
☐Yes ☐No
Explain_____

◆Do you experience struggles with providing for your family? (e.g. food/formula, medications, health coverage)
☐Yes ☐No
Explain_____

Biological Family History ☐Don't know

*Please note, if you (the patient) are 18+ years, these questions pertain to you

Have any immediate family members had the following?

Alcohol abuse	☐Yes	☐No	If yes, relationship to patient_____
Anemia	☐Yes	☐No	If yes, relationship to patient_____
Asthma	☐Yes	☐No	If yes, relationship to patient_____
Bed-wetting (after 10 years old)	☐Yes	☐No	If yes, relationship to patient_____
Bleeding disorder	☐Yes	☐No	If yes, relationship to patient_____
Cancer (before 55 years old)	☐Yes	☐No	If yes, relationship to patient_____
Childhood hearing loss	☐Yes	☐No	If yes, relationship to patient_____
Dental decay	☐Yes	☐No	If yes, relationship to patient_____
Developmental disability	☐Yes	☐No	If yes, relationship to patient_____
Diabetes (before 55 years old)	☐Yes	☐No	If yes, relationship to patient_____
Drug abuse	☐Yes	☐No	If yes, relationship to patient_____
Epilepsy or convulsions	☐Yes	☐No	If yes, relationship to patient_____
Heart Disease (before 55 years old)	☐Yes	☐No	If yes, relationship to patient_____
High cholesterol	☐Yes	☐No	If yes, relationship to patient_____
Hypertension	☐Yes	☐No	If yes, relationship to patient_____
Kidney disease	☐Yes	☐No	If yes, relationship to patient_____
Liver disease	☐Yes	☐No	If yes, relationship to patient_____
Mental illness/depression	☐Yes	☐No	If yes, relationship to patient_____
Obesity	☐Yes	☐No	If yes, relationship to patient_____
Sudden death (before 50 years old)	☐Yes	☐No	If yes, relationship to patient_____
Tobacco use	☐Yes	☐No	If yes, relationship to patient_____
Tuberculosis	☐Yes	☐No	If yes, relationship to patient_____
Additional Family History	☐Yes	☐No	If yes, relationship to patient_____

Past History ☐ Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Does your child have, or has your child ever had:

ADHD/anxiety/mood problems/depression ☐Yes ☐No Explain_____
Allergies (food/medication/seasonal) ☐Yes ☐No Explain_____
Anemia or bleeding problem ☐Yes ☐No Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia ☐Yes ☐No Explain_____
Bed-wetting (after 5 years old) ☐Yes ☐No Explain_____
Blood transfusion ☐Yes ☐No Explain_____
Cancer/bone marrow transplant ☐Yes ☐No Explain_____
Chemotherapy ☐Yes ☐No Explain_____
Chickenpox ☐Yes ☐No Explain_____
Chronic or recurrent skin problems (ex: acne, eczema) ☐Yes ☐No Explain_____
Congenital cataracts/retinoblastoma ☐Yes ☐No Explain_____
Constipation requiring doctor visits ☐Yes ☐No Explain_____
Convulsions or other neurologic problems ☐Yes ☐No Explain_____
Dental decay ☐Yes ☐No Explain_____
Developmental delay ☐Yes ☐No Explain_____
Diabetes ☐Yes ☐No Explain_____
(For females) Has had first period? ☐Yes ☐No Age_____
(For females) Regular period or menstrual cycle ☐Yes ☐No Explain_____
Frequent abdominal pain ☐Yes ☐No Explain_____
Frequent ear infections ☐Yes ☐No Explain_____
Frequent headaches ☐Yes ☐No Explain_____
Heart problem or heart murmur ☐Yes ☐No Explain_____
High blood pressure ☐Yes ☐No Explain_____
History of family violence ☐Yes ☐No Explain_____
History of serious injuries/fractures/concussions ☐Yes ☐No Explain_____
HIV ☐Yes ☐No Explain_____
Kidney disease or urologic malformations ☐Yes ☐No Explain_____
Metabolic/Genetic disorders ☐Yes ☐No Explain_____
Obesity ☐Yes ☐No Explain_____
Organ transplant ☐Yes ☐No Explain_____
Problems with ears or hearing ☐Yes ☐No Explain_____
Problems with eyes or vision ☐Yes ☐No Explain_____
Recurrent urinary tract infections and problems ☐Yes ☐No Explain_____
Sleep problems; snoring ☐Yes ☐No Explain_____
Thyroid or other endocrine problems ☐Yes ☐No Explain_____
Use of tobacco, alcohol or drugs ☐Yes ☐No Explain_____

Any other significant problem? _____

Communication Needs ☐ Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Language spoken/understood if other than English: Child _____ Parent(s)_____
Any special communication needs? ☐Yes ☐No Explain_____

Patient Education Assesment ☐ Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Would you prefer patient education be provided to you or your child by:

☐ Demonstration ☐ Written Materials ☐Other Explain_____

Patient Rights ☐ Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Is there anything we need to know about your religion or culture that may affect or interfere with caring for your child?

☐Yes ☐No

Explain_____