

## Gordon - Klinow Pediatrics

### Initial History Questionnaire

Name: \_\_\_\_\_ Date Of Birth: \_\_\_\_\_ Allergies: \_\_\_\_\_  NKDA

### Household Please list all immediate family members (siblings, parents, grandparents)

Name	Relationship	Birthdate	Health Problems

Birth hospital \_\_\_\_\_  
 Obstetrician \_\_\_\_\_  
 Birth weight \_\_\_\_\_ Length \_\_\_\_\_  
 Vaginal  Cesarean If cesarean, why \_\_\_\_\_  
 Term  Early (weeks \_\_\_\_\_)  Late  
 Any pre-natal problems? Any post-natal problems? \_\_\_\_\_  
 \_\_\_\_\_  
 Initial feeding  breast (how long? \_\_\_\_\_ weeks)  formula  
 During pregnancy did mother  smoke?  drink?  Use drugs?

**General:** Do you consider your child to be in good health?  yes  no, Explain \_\_\_\_\_

Any serious medical condition?  no  yes, Explain \_\_\_\_\_

Any hospitalizations??  no  yes, Explain \_\_\_\_\_

Any allergies to medications??  no  yes, Explain \_\_\_\_\_

Other serious allergies??  no  yes, Explain \_\_\_\_\_

On any medications??  no  yes, Explain \_\_\_\_\_

Concerned about physical/mental/emotional development?  no  yes, Explain \_\_\_\_\_

Which school? Which Grade? Previous failure of a grade? Current progress? \_\_\_\_\_

**Family History:** Have any family members had the following:  Check if none of below

Illness	Yes	Who	Illness	Yes	Who	Illness	Yes	Who
Nasal allergies			Anemia/Blood			Substance Abuse		
↑ Cholesterol			Diabetes			Mental Retardation		
Tuberculosis			Asthma			Epilepsy/Seizures		
Eye or Vision			Deafness			Congenital defects		
Kidney/Bladder			Thyroid			Cancer before 50		
↑ Blood Press.			Migraines			Cardiac before 50		
Mental Illness			Ulcers			Bleeding Problems		
Chronic Skin			Alcoholism			Immune Problems		