Frederick Pediatric Associates
Initial History Questionnaire

Patient Name: ____ DOB:___________ Sex: ☐ Male ☐ Female
Previous Medical Doctor/Birth Hospital:_________________________________ Last Visit: ________________________
Are the patient's immunizations up to date? ☐ Yes ☐ No Do you have the immunization record? ☐ Yes ☐ No
Dentist Name: ____ Last Visit: ___________________________
Father's Name/DOB: _____________________________ Mother's Name/DOB: ____________________________
Father's Contact Phone: ___________________________ Mother's Contact Phone:_____________________________
Social Security Number: ___________________________ Social Security Number: _____________________________

Allergies	**Current Medications**
Is your child allergic to any foods, medications, chemicals, plants, other? ☐ Yes ☐ No If yes, please list: Name Reaction ___________ ___________	Please list current medications. ___________ ___________ ___________ ___________

Pregnancy and Birth

Is the patient yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Other: ____
Mother's Name: ____________________________________ Age at Birth: ________________________________
Check if mother had any of the following complications during pregnancy or delivery:

☐ Tobacco Use ☐ Substance Abuse ☐ Injections ☐ Diabetes
☐ Bleeding ☐ Rashes ☐ Fever ☐ High Blood Pressure

Medications during pregnancy: ____
Baby's Birth Weight: _____________________________ Type of Delivery: ☐ Vaginal ☐ Cesarean
Was baby on time? ☐ Yes ☐ No If no, how early or late was the baby? ________________________________
How many days did the baby stay in the hospital? _______ Complications (List):_________________________________

Please provide our office with copies of any hospital records.

Patient History

Check if your child has had any of the following:

☐ ADD/ADHD ☐ Allergies ☐ Anemia ☐ Autism
☐ Constipation ☐ Depression ☐ Diarrhea ☐ Ear Infection
☐ Eczema ☐ Hearing Loss ☐ Heart Disease ☐ Pneumonia
☐ Rash ☐ Reflux ☐ Seizures ☐ Urinary Problems
☐ Cancer: _____________ ☐ Chicken Pox: Date: __________________ ☐ Other: ________________________

Has the patient had any hospitalizations or surgeries? ☐ Yes ☐ No
If yes, please list date, name of hospital, injury or illness: ____

____

At what age did your child sit alone? ______________
At what age did your child walk alone? ______________
At what age did your child say words? _______________

Do you have any concerns? Check applicable.
☐ Speech ☐ School
☐ Development ☐ Behavior

Continue to next page

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Family and Social Profile

Mother's Full Name: ___________________________
Mother's Age: ______________
Lives with Patient? ☐ Yes ☐ No

Are Mother and Father:
☐ Married ☐ Separated ☐ Divorced ☐ Other: __________

Child Care: ☐ Parents ☐ Other (Specify) ____________

House built before 1978? ☐ Yes ☐ No
Are there guns in the home? ☐ Yes ☐ No
Are there pets in the home? ☐ Yes ☐ No
Any foreign travel in the past 5 years? ☐ Yes ☐ No
Are there any smokers in the household? ☐ Yes ☐ No
If yes, do they smoke inside the home or outside? ☐ Inside ☐ Outside

Father's Full Name: ____________________________
Father's Age: _____________
Lives with Patient? ☐ Yes ☐ No

Sibling Names	DOB	Lives with patient?

Family Medical History

Check any of the following that apply to blood relatives of the PATIENT.
Please list maternal or paternal family members; Parent, Sibling, Grandparent, Aunt or Uncle.

☐ AIDS/HIV/Immune: ____
☐ Alcoholism : ____
☐ Allergies: ____
☐ Anemia: ____
☐ Arthritis: ____
☐ Asthma: ____
☐ Birth Defects/Genetic Disorder: ____
☐ Cancer: ____
☐ Depression/Mental Illness: ____
☐ Diabetes: ____
☐ Drug Abuse: ____
☐ GI Disease ____
☐ Hearing Loss: ____
☐ Heart Murmur/Disease: ____
☐ High Blood Pressure: ____
☐ High Cholesterol: ____
☐ Kidney/Liver Disease: ____
☐ Migraines: ____
☐ Seizures: ____
☐ SIDS: ____
☐ Stroke before age 55**:** ____
☐ Thyroid Disease: ____
☐ Tuberculosis: ____
☐ Other: ____