TLC PEDIATRICS & ADOLESCENT HEALTH, PA
24 PLAZA 9
ENGLISH TOWN, NEW JERSEY
07726
PHONE: 732-431-0505
FAX-732-294-2470

Initial History Questionnaire

Name			
ID Number			
Form Completed By	Birth Date	Age	Gender
Date completed			Male Female

House Hold

Please list all those who live in Child's Home

Name	Relation to Child	Birth Date	Health problems

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

If mother and father are not Living together or if child does not live with parents, what is the child's custody status?

If one or both parents are not Living in the home, how often he/she see the parent/parents not in the home?

Birth History

Birth Weight:

Was the baby born at term □ Early □ Late

If early ,how many weeks gestation

Did mother have any illness or problem with her pregnancy?

□ Yes □ No □ Explain

During pregnancy , did mother

Smoke □ Yes □ No Drink Alcohol □Yes □No

Use drugs or Medications ☐ Yes ☐No

What

When

Was the delivery □ Vaginal □ Cesarean

If Cesarean, Why?

Did your baby have any problems right after birth?

□ Yes □ No □ Explain

Was Initial feeding □ Breast □Bottle

Did your baby go home with mother from the hospital?

☐Yes ☐ No ☐Explain

General

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Do you consider your child to be in good health ?	☐ Yes ☐ No Explain_____
Does your child have any serious illness or medical condition?	☐ Yes ☐ No Explain_____
Has your child had serious injuries or accidents?	☐ Yes ☐ No Explain_____
Has your child had any Surgery?	☐ Yes ☐ No Explain_____
Has your child ever been hospitalized?	☐ Yes ☐ No Explain_____
Is your child allergic to any medicines or drugs?	☐ Yes ☐ No Explain_____

Development

Are you concerned about your child's physical development?	☐ Yes ☐ No Explain_____
Are you concerned about your child's mental or emotional development?	☐ Yes ☐ No Explain_____
Are you concerned about your child's attention Span?	☐ Yes ☐ No Explain

If your child in School:
How is his/her behavior in school?_____

Has he/she failed or repeated a grade in school?_____

How is he/she doing in Academic subjects ?_____

Is he/she in special or Resource classes?_____

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Family History

Have any family members had the following

Deafness	☐ Yes	☐No	Who_____	Comments_____
Nasal Allergies	☐ Yes	☐No	Who_____	Comments_____
Asthma	☐ Yes	☐No	Who_____	Comments_____
Tuberculosis	☐ Yes	☐No	Who_____	Comments_____
Heartdisease (before 50 years old)	☐ Yes	☐No	Who_____	Comments_____
High Blood pressure (before 50 years old)	☐ Yes	☐No	Who_____	Comments_____
High Cholesterol	☐ Yes	☐No	Who_____	Comments_____
Anemia	☐ Yes	☐No	Who_____	Comments_____
Biceding Disorder	☐ Yes	☐No	Who_____	Comments_____
Liver Disease	☐ Yes	☐No	Who_____	Comments_____
Kidney Disease	☐ Yes	☐No	Who_____	Comments_____
Diabetes (before 50 years old)	☐ Yes	☐No	Who_____	Comments_____
Bed-wetting (after 10 years old)	☐ Yes	☐No	Who_____	Comments_____
Epilepsy or convulsions	☐ Yes	☐No	Who_____	Comments_____
Alcohol abuse	☐ Yes	☐No	Who_____	Comments_____
Drug abuse	☐ Yes	☐No	Who_____	Comments_____
MentalIllness	☐ Yes	☐No	Who_____	Comments_____
Mental Retardation	☐ Yes	☐No	Who_____	Comments_____
Immune problems HIV or Aids	☐ Yes	☐No	Who_____	Comments_____

Additional Comments _____
_____
_____

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Past History	
Does your child have , or has he/she have ever had:	
Chicken Pox	☐ Yes ☐ No Explain_____
Frequent Ear Infections	☐ Yes ☐ No Explain_____
Problems with ears/hearing	☐ Yes ☐ No Explain_____
Nasal Allergies	☐ Yes ☐ No Explain_____
Problems with Eyes or vision	☐ Yes ☐ No Explain_____
Asthma, bronchitis ,bronchiolitis ,or pneumonia	☐ Yes ☐ No Explain_____
Any heart problem or heart murmur	☐ Yes ☐ No Explain_____
Anemia or bleeding problem	☐ Yes ☐ No Explain_____
Blood Transfusion	☐ Yes ☐ No Explain_____
Frequent Abdominal pain	☐ Yes ☐ No Explain_____
Constipation requiring doctor visits	☐ Yes ☐ No Explain_____
Bladder or Kidney Infection	☐ Yes ☐ No Explain_____
Bed-Wetting (after 5 years old)	☐ Yes ☐ No Explain_____
(For girls) Has she started her Menstrual periods	☐ Yes ☐ No Explain_____
(For Girls)Are there problems with her periods	☐ Yes ☐ No Explain_____
Any chronic or recurrent skin problem (acne ,eczema etc)	☐ Yes ☐ No Explain_____
Frequent Headaches	☐ Yes ☐ No Explain_____
Convulsions or other neurologic problems	☐ Yes ☐ No Explain_____
Diabetes	☐ Yes ☐ No Explain_____
Thyroid or other Endocrine problem	☐ Yes ☐ No Explain_____
Any other significant problem	☐ Yes ☐ No Explain_____
Use of Alcohol or drugs	☐ Yes ☐ No Explain_____