B. J. Anarumo, D. O., P.A., F.A.C.O.P.

Initial Patient History Questionnaire

All Information must be completed - PLEASE PRINT CLEARLY

PATIENT NAME

COMPLETED BY | RELATIONSHIP TO PATIENT | BIRTH DATE

DATE COMPLETED | AGE M F

HOUSEHOLD

Please list all those living in the child's home

NAME	RELATIONSHIP TO CHILD	BIRTH DATE	LIST ANY HEALTH PROBLEMS

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

If mother and father are not living together or if the 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 does he/she see the parent/parents not in the home?

BIRTH HISTORY

Birth Weight:: _____

Was the baby born at term? ___YES ___NO ____Early ____ Late

If early, how many weeks' gestation? _____

Did mother have any illness or problems with her pregnancy?

[_] Yes [_] No If yes, explain:_____

During pregnancy, did mother; Smoke: [_] Y [_]N Drink Alcohol: [_]Y [_]N

Use Drugs or medications: [_]Y [_] N

List drugs or medications and when used: _____

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

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_____

*CONTINUED ON NEXT PAGE

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 is 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?
_____

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: _____

Heart Disease (before age 50) [_] Yes [_] No Who? _____ Comments: _____

High Blood Pressure (before age 50) [_] Yes [_] No Who? _____ Comments: _____

High Cholesterol [_] Yes [_] No Who? _____ Comments: _____

Anemia [_] Yes [_] No Who? _____ Comments: _____

Bleeding Disorder [_] Yes [_] No Who? _____ Comments: _____

Liver Disease [_] Yes [_] No Who? _____ Comments: _____

Kidney Disease [_] Yes [_] No Who? _____ Comments: _____

Diabetes (before age 50) [_] Yes [_] No Who? _____ Comments: _____

Bed-wetting (after age 10) [_] Yes [_] No Who? _____ Comments: _____

Epilepsy or convulsions [_] Yes [_] No Who? _____ Comments: _____

Alcohol Abuse [_] Yes [_] No Who?_____ Comments: _____

Drug Abuse [_] Yes [_] No Who?_____ Comments: _____

Mental Illness [_] Yes [_] No Who? _____ Comments: _____

Mental Retardation [_] Yes [_] No Who?_____ Comments:_____

Immune problem, HIV or AIDS, [_] Yes [_] No Who?_____ Comments: _____

Additional family History: _____

_____

*CONTINUED ON NEXT PAGE

PAST HISTORY

Does your child have, or has he/she ever had:

Chickenpox [_] Yes [_] No When: _____

Frequent Ear infections [_] Yes [_] No Explain: _____

Problems with ears or hearing [_] Yes [_] No Explain: _____

Nasal Allergies [_] Yes [_] No Explain: _____

Problems with eyes or vision [_] Yes [_] No Explain: _____

Asthma, bronchitis, 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 age 5) [_] Yes [_] No Explain: _____

(For girls) Has she started her menstrual periods? [_] Yes [_] No When: _____

(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 neurological problem [_] Yes [_] No Explain: _____

Diabetes [_] Yes [_] No Explain: _____

Thyroid or other endocrine problem [_] Yes [_] No Explain: _____

Any other significant problem [_] Yes [_] No Explain: _____

Use of any alcohol or drugs [_] Yes [_] No Explain: _____

_____ _____

Signature of Person who completed form Date

_____ _____

Physician's Signature Date