Brighton Pediatric Center

Initial History Questionnaire

Name

DOB

Reason for today's visit:

Today's date

Previous Doctor/ office:

PREGNANCY & BIRTH (Please complete: If patient is less than 5 yrs old)

Number of Pregnancies before this one

How long was this pregnancy? WKs

Any Illness during pregnancy? ☐N ☐Y

Medications during pregnancy? ☐N ☐Y

Smoking while pregnant? ☐N ☐Y

Alcohol/ Drugs in pregnancy? ☐N ☐Y

Type of delivery? ☐Natural ☐ Breech ☐ Vacuum ☐ C/ Section

Complications? ☐N ☐Y

Birth Weight Lbs Oz Length inch

Length of hospital stay:

Any problem at birth/ after ☐N ☐Y

FEEDING & NUTRITION

Food Allergies:

Feeding : ☐Breast Duration months/weeks

☐Formula Brand

☐Solid Foods:

Vitamins ☐N ☐Y Brand?

Fluoride ☐N ☐Y Dose?

Special Diet? ☐N ☐Y

Feeding Problem ☐N ☐Y

FAMILY PROFILE

Parents: ☐Married ☐Divorced ☐Separated ☐Single

Child lives with: ☐Both parents ☐Mother ☐Father

☐Guardian

Age of house/ Apartment Yrs

Any pets? ☐N ☐Y:

Has any parent, sibling died? ☐N ☐Y

Who? Reason?

PAST MEDICAL HISTORY

Allergic reactions? ☐Medicine ☐Food ☐Animal ☐Insect bites

Medication taken on regular basis:

Hospitalization: (When-Where-Why)

☑ ***Please check if any of the following ever occurred?***

☐ Measles/ Rubella	☐ Pneumonia
☐ Mumps	☐ Concussion
☐ Chickenpox	☐ Convulsions/ Seizures
☐ Whooping cough	☐ Ear Infections
☐ Scarlet Fever	☐ Strep Throat
☐ Eczema	☐ UTI
☐ Heart Disease	☐ Hepatitis
☐ Asthma/ wheezing	☐ Fracture
☐ Anemia	☐ Learning Problems
☐ Bleeding tendency	☐ Problems with vision
☐ Blood transfusion	☐ Problem with hearing
☐ Joint problems	☐ Others

FAMILY MEDICAL HISTORY

Please check the box of your child's blood relatives who have ever had any of the following conditions:	Father	Mother	Sibling	F Side	M Side
Asthma					
Migraine Headache					
High Blood Pressure					
High Cholesterol					
Heart Attack at early age (before 50yr)					
Anemia/ Blood Disease					
Stomach, Duodenal Ulcers					
Crohn's, Ulcerative Colitis, Polyps					
Liver, gallbladder disease					
Cystic Fibrosis					
Seizures/ Convulsions					
Muscle weakness/ Dystrophy					
Learning disability/ ADHD					
Mental Illness (Bipolar, OCD, Anxiety)					
Alcoholism					
Tuberculosis/ AIDS					
Thyroid Problems					
Early deafness					
Diabetes					

DEVELOPMENT AND BEHAVIOR

At what age your child:

Sat alone Walked Fed self

Talked (2-3 words sentences)

Toilet trained: Day Night

Development compared to other children?

Grade in school Problems in school ☐N ☐Y

Learning problem? ☐N ☐Y

Behavioral Problems? ☐N ☐Y

Bedwetting? ☐N ☐Y

Nail biting? ☐N ☐Y

Sleeping Problems? ☐N ☐Y