NC Child Health Program Initial History Questionnaire *(created 7/1/2012)*

Patient Name:	Date of Birth:	Sex: (Circle) Male Female
Person Who Filled Out Form: Date Filled Out:	Relationship to Patient:	

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes
Birth Weight: _____ pounds _____ ounces
Was baby born on time? No Yes _____ weeks
Was the birth Vaginal C-Section If C-Section, Why?_____
_____
Were there any problems during the pregnancy or at birth?
No Yes If yes, explain: _____
_____
During pregnancy did mom:
Use tobacco? No Yes Drink alcohol? No Yes
Use drugs or other medications? No Yes What: _____
Use prenatal vitamins? No Yes When:_____
Did baby have problems or need to stay in a NICU?
No Yes If yes, explain: _____
The initial feeding for the baby was: Formula Breast milk
How long did the baby breastfeed? _____
Did the baby go home with mom? No Yes
If no, explain: _____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:
_____
_____
_____
Are there siblings not listed? If so, list names, ages and where they live:
_____
_____
What is your child's living situation?

Joint custody Single custody Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?
_____
Tobacco use in family? No Yes Who?: _____

CHILD'S HEALTH HISTORY

Has the **child** ever had:

Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other:		
_____	No	Yes
Chicken Pox (Year) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other: _____	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone in **the family of the child** (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/Takes Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell ¬	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse ¬	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History:			
_____	No	Yes	_____

Additional Comments: