Cohen Children's Medical Center
Northwell Health

General Pediatrics

Initial History Questionnaire

Form Completed By _____ Date Completed _____

Patient Name _____ Date of Birth _____

Preferred Pharmacy Name, Address and Phone Number _____

Household

***Please note, if you (the patient) are 18+ years, these questions pertain to you**

Please list all those living in the child's home.

Name	Relationship to Child	Birth Date

Parent 1: _____
Name

Occupation:_____

Highest Level of Education: ❒Grade School ❒High School ❒Bachelor's Degree ❒Post Graduate Degree

Parent 2: _____
Name

Occupation:_____

Highest Level of Education: ❒Grade School ❒High School ❒Bachelor's Degree ❒ Post Graduate Degree

◆Who does the child live with?

❒ Lives with biological parents ❒ Lives with adoptive parents ❒ Joint Custody ❒Single Custody ❒ Lives with foster family ❒Other_____

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

_____

◆If one or both parents are not living in the home, how often does the child see the parent(s) not in the home?

_____

Birth History

❒**Don't know birth history**

***Please note, if you (the patient) are 18+ years, these questions pertain to you**

Birth Weight_____ Birth Length_____

Was the baby born at term? _____ or _____weeks

Were there any prenatal or neonatal complications?

❒Yes ❒No Explain_____

Was a NICU stay required? ❒Yes ❒No

Explain_____

During pregnancy, did mother:

◆Use tobacco? ❒Yes ❒No

◆Drink alcohol? ❒Yes ❒No

◆Use drugs/medications? ❒Yes ❒No

◆Take prenatal vitamins? ❒Yes ❒No

Was the delivery ❒Vaginal ❒Cesarean

If cesarean, why? _____

Was initial feeding ❒Formula ❒Breast milk

How long breastfed?_____

Did child go home with mother from the hospital?

❒Yes ❒No Explain_____

_____

Safety and Lifestyle

❒**Don't know**

***Please note, if you (the patient) are 18+ years, these questions pertain to you**

◆Are there any guns in the child's home?

❒Yes ❒No

◆If yes, are appropriate safety measures in place?

❒Yes ❒No

◆Does the child use a car seat or seat belt at all times?

❒Yes ❒No

◆Is the hot water temperature less than 125°F?

❒Yes ❒No

◆Does anyone smoke in your home and/or car?

❒Yes ❒No

◆Are there smoke detectors at home?

❒Yes ❒No

◆Are there carbon monoxide detectors at home?

❒Yes ❒No

◆Does the child's home have exposure to lead paint?

❒Yes ❒No

◆Are there any pets at home?

❒Yes ❒No If yes, type?_____

◆How many hours per day does your child watch television/play video games? _____ Get exercise?_____

General ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

◆Do you consider your child to be in good health?
❒Yes ❒No
Explain_____

◆Does your child have any serious illnesses or medical conditions?
❒Yes ❒No
Explain_____

◆Has your child had any surgery?
❒Yes ❒No
Explain_____

◆Has your child ever been hospitalized?
❒Yes ❒No
Explain_____

◆Does your child take any daily medications? (including prescriptions, over the counter medications & vitamins)
❒Yes ❒No
Explain_____

◆Has your child ever had an allergic reaction to any medicine or food?
❒Yes ❒No
Explain_____

◆Is your child receiving or has previously received any services? (e.g. Physical/Occupational/Speech Therapy)
❒Yes ❒No
Explain_____

◆Do you experience struggles with providing for your family? (e.g. food/formula, medications, health coverage)
❒Yes ❒No
Explain_____

Biological Family History ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Have any immediate family members had the following?

Alcohol abuse	❒Yes	❒No	If yes, relationship to patient_____
Anemia	❒Yes	❒No	If yes, relationship to patient_____
Asthma	❒Yes	❒No	If yes, relationship to patient_____
Bed-wetting (after 10 years old)	❒Yes	❒No	If yes, relationship to patient_____
Bleeding disorder	❒Yes	❒No	If yes, relationship to patient_____
Cancer (before 55 years old)	❒Yes	❒No	If yes, relationship to patient_____
Childhood hearing loss	❒Yes	❒No	If yes, relationship to patient_____
Dental decay	❒Yes	❒No	If yes, relationship to patient_____
Developmental disability	❒Yes	❒No	If yes, relationship to patient_____
Diabetes (before 55 years old)	❒Yes	❒No	If yes, relationship to patient_____
Drug abuse	❒Yes	❒No	If yes, relationship to patient_____
Epilepsy or convulsions	❒Yes	❒No	If yes, relationship to patient_____
Heart Disease (before 55 years old)	❒Yes	❒No	If yes, relationship to patient_____
High cholesterol	❒Yes	❒No	If yes, relationship to patient_____
Hypertension	❒Yes	❒No	If yes, relationship to patient_____
Kidney disease	❒Yes	❒No	If yes, relationship to patient_____
Liver disease	❒Yes	❒No	If yes, relationship to patient_____
Mental illness/depression	❒Yes	❒No	If yes, relationship to patient_____
Obesity	❒Yes	❒No	If yes, relationship to patient_____
Sudden death (before 50 years old)	❒Yes	❒No	If yes, relationship to patient_____
Tobacco use	❒Yes	❒No	If yes, relationship to patient_____
Tuberculosis	❒Yes	❒No	If yes, relationship to patient_____
Additional Family History	❒Yes	❒No	If yes, relationship to patient_____

Past History ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Does your child have, or has your child ever had:

ADHD/anxiety/mood problems/depression ❒Yes ❒No Explain_____
Allergies (food/medication/seasonal) ❒Yes ❒No Explain_____
Anemia or bleeding problem ❒Yes ❒No Explain_____
Asthma, bronchitis, bronchiolitis, or pneumonia ❒Yes ❒No Explain_____
Bed-wetting (after 5 years old) ❒Yes ❒No Explain_____
Blood transfusion ❒Yes ❒No Explain_____
Cancer/bone marrow transplant ❒Yes ❒No Explain_____
Chemotherapy ❒Yes ❒No Explain_____
Chickenpox ❒Yes ❒No Explain_____
Chronic or recurrent skin problems (ex: acne, eczema) ❒Yes ❒No Explain_____
Congenital cataracts/retinoblastoma ❒Yes ❒No Explain_____
Constipation requiring doctor visits ❒Yes ❒No Explain_____
Convulsions or other neurologic problems ❒Yes ❒No Explain_____
Dental decay ❒Yes ❒No Explain_____
Developmental delay ❒Yes ❒No Explain_____
Diabetes ❒Yes ❒No Explain_____
(For females) Has had first period? ❒Yes ❒No Age_____
(For females) Regular period or menstrual cycle ❒Yes ❒No Explain_____
Frequent abdominal pain ❒Yes ❒No Explain_____
Frequent ear infections ❒Yes ❒No Explain_____
Frequent headaches ❒Yes ❒No Explain_____
Heart problem or heart murmur ❒Yes ❒No Explain_____
High blood pressure ❒Yes ❒No Explain_____
History of family violence ❒Yes ❒No Explain_____
History of serious injuries/fractures/concussions ❒Yes ❒No Explain_____
HIV ❒Yes ❒No Explain_____
Kidney disease or urologic malformations ❒Yes ❒No Explain_____
Metabolic/Genetic disorders ❒Yes ❒No Explain_____
Obesity ❒Yes ❒No Explain_____
Organ transplant ❒Yes ❒No Explain_____
Problems with ears or hearing ❒Yes ❒No Explain_____
Problems with eyes or vision ❒Yes ❒No Explain_____
Recurrent urinary tract infections and problems ❒Yes ❒No Explain_____
Sleep problems; snoring ❒Yes ❒No Explain_____
Thyroid or other endocrine problems ❒Yes ❒No Explain_____
Use of tobacco, alcohol or drugs ❒Yes ❒No Explain_____

Any other significant problem? _____

Communication Needs ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Language spoken/understood if other than English: Child _____ Parent(s)_____
Any special communication needs? ❒Yes ❒No Explain_____

Patient Education Assesment ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Would you prefer patient education be provided to you or your child by:

❒ Demonstration ❒ Written Materials ❒Other Explain_____

Patient Rights ■Don't know *Please note, if you (the patient) are 18+ years, these questions pertain to you

Is there anything we need to know about your religion or culture that may affect or interfere with caring for your child?
❒Yes ❒No
Explain_____