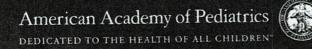
Initial History Questionnaire					Name ID NUMBER						
FORM COMPLETED BY		DATE	DATE COMPLETED		BIRTH DATE		AGE M				
Uawahak											
Household											
Please list all those	living in the child's h	Birth Health			Are then	e siblings not listed? If so and where they live	o, please list their n	ames			
Name	to child	date problem	ns								
					If mother	r and father are not livin with parents, what is the	ng together or if ch child's custody sta	ild does tus?			
					If one or does he/	both parents are not li she see the parent/pare	ving in the home, h nts not in the hom	ow often			
Birth Hist	orv										
				Was	he delive	ry □ Vaginal? □	Cesarean?				
The second second second		Early! L				, ,,					
	any illness or problem	m with her pregnancy	2	☐ Ye		Explain					
☐ Yes ☐ No	Explain										
						ling 🗆 Breast? 🗆					
During pregnancy, Smoke ☐ Yes ☐		Drink alcohol	Yes 🗆 No		our baby	go home with mother for Explain	rom the hospital!				
Hea drugs or med	lications T Yes T										
		vviieii									
General											
	your child to be in g					Explain					
Does your child h	ave any serious illne	ss or medical condition	n?	☐ Yes		Explain					
Has your child had	d serious injuries or	accidents?		☐ Yes	□ No	Explain					
Has your child ha	d any surgery?			☐ Yes	□ No	Explain					
Has your child ever been hospitalized?						Explain					
Is your child aller	gic to any medicines	or drugs?		☐ Yes	∐ No	Explain					
Developm	nent										
Particular de la constant de la cons		physical development	2	☐ Yes	□ No	Explain					
		mental or emotional		☐ Yes	□ No	Explain					
	ed about your child's					Explain					
If your child is in											
	ial an managemen classe										



Family History							
lave any family members had the following	×.						
Deafness	☐ Yes	No	Who		c	omments	
Nasal allergies	☐ Yes	No	Who		c	omments	
Asthma	☐ Yes	No	Who		c	omments	
Tuberculosis	☐ Yes	No	Who		c	omments	
Heart disease (before 50 years old)	☐ Yes	No	Who		c	omments	
High blood pressure (before 50 years old)	☐ Yes	No	Who		c	omments	
ligh cholesterol	☐ Yes	No	Who		c	omments	
Anemia	☐ Yes	No	Who		c	omments	
Bleeding disorder	☐ Yes	No	Who	-		Comments	
iver 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				Comments	
Epilepsy or convulsions	☐ Yes	No	Who		(Comments	
Alcohol abuse	☐ Yes	No	Who		(Comments	
Drug abuse	☐ Yes	No				Comments	
Mental illness	☐ Yes	No	Who			Comments	
Mental retardation	☐ Yes	No				Comments	
Immune problems, HIV, or AIDS	☐ Yes	No	Who		(Comments	
Additional family history							
Does your child have, or has he/she ever	nad:	ПУ	, П	No	When		
Past History	had:						
Chickenpox		□ Ye	s 🗆	No	When		
Frequent ear infections		□ Ye	s 🗆	No	Explain		
Problems with ears or hearing		□ Ye	s 🗆	No	Explain		
Nasal allergies		□ Ye	s 🗆	No	Explain		
Problems with eyes or vision		□ Ye	s D	No		***************************************	
Asthma, bronchitis, bronchiolitis, or pneu	monia	□ Ye	as 🗆	No			
Any heart problem or heart murmur		□ Ye	es 🗆	No	- 10 - 10 - 10 - 10 - 10 - 10 - 10 - 10		
Anemia or bleeding problem		□ Y	es 🗆	No			
Blood transfusion		□ Y	es 🗆	No			
Frequent abdominal pain		□ Y	es 🗆	No			
Constipation requiring doctor visits		□ Y	es 🗆	No			
Bladder or kidney infection		□ Y	es 🗆	No			
Bed-wetting (after 5 years old)		□ Y	es \square	No			
(For girls) Has she started her menstrua	periods?	□ Y	es 🗆	No		was a second of the second of	
(For girls) Are there problems with her	periods?	DY	es 🗀	No	1 1 1 1 1 1 1 1 1		
Any chronic or recurrent skin problem (acne, eczema, etc)		DY	es 🗆	No			
Frequent headaches			es C	No	and the state of the same		
Convulsions or other neurologic proble	m	0 1	es [No		·	
Diabetes		ο,		No.		·	
Thyroid or other endocrine problem		□,	res [] No	Cuminin		
Any other significant problem)	
raily outer significant problem		ο,	res D] No	Explair)) 1	

Exposures			
Is your child exposed to cigarette smoke?	☐ Yes	☐ No	Explain:
Is your child exposed to tuberculosis?	Yes	□No	Explain:
Does your child have contact with pets or other animals?	Yes	□No	Explain:
Is either parent abusing substances?	Yes	□No	Explain:
Has your child been physically abused?	Yes	□No	Explain:
Has your child ever suffered from physical neglect?	Yes	□No	Explain:
Has your child been exposed to sexual contact without consent?	Yes	No	Explain:
Complete below ONLY if chi	ld is 6 yea	ırs old	or younger
Lead Questionnaire			
Does the child live in or frequently spend time in a house built before 19		peeling	or chipping paint?
	∐ Yes	∐No	Explain:
Does the child live in a house built before 1960 that is being or will be re	enovated?	□No	Explain:
Has the child or its playmate had lead poisoning?	Yes	□No	Explain:
Does the child come in frequent contact with an adult who works with l	ead, such as	constru	ction, welding, pottery or other kinds of trades? Explain:
Does the child live near a lead smelter, battery recycling plant or other l	lead <u>in</u> dustry	/?	
	Yes	☐ No	Explain:
Does the child receive any home remedies that may contain lead?	Yes	☐ No	Explain:
Does the child live near a busy highway where soil and dust may be con	taminated w	vith lead	? Explain:
Does the plumbing in your home had lead pipes or copper with lead join			
Child's name			
Parent's/Guardian's Signature			Date