Ridgecrest
RURAL HEALTH CLINIC
A Service of Ridgecrest Regional Hospital

Initial History Questionnaire

Name: _____

Birth date: _____ Age: _____ M _____ F _____

Form completed by: _____ Relationship: _____

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

Name	Relationship	Birth date	Health problems

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

_____

Does the child live with: ☐ Biological parents ☐ Adoptive parents ☐ Foster family ☐ Joint custody ☐ Single custody?

Birth History:

Birth weight: _____ was the child born term or preterm? _____

weeks at birth? _____ were there any prenatal or neonatal complications? ☐ Yes

☐ No. If yes, explain: _____

_____

_____

_____

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Was the birth ☐ Vaginal ☐ Cesarean? If Cesarean, why? _____

_____

Did the baby have to stay in the hospital for any reason? ☐ Yes ☐ No

If yes, explain: _____

During pregnancy did mother: use tobacco: ☐ Yes ☐ No, drink alcohol: ☐ Yes ☐ No,

use illegal drugs: ☐ Yes ☐ No, use medications: ☐ Yes ☐ No, use prenatal vitamins: ☐ Yes ☐ No,

If yes to any of the above explain: _____

_____

General:

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 surgeries? ☐ Yes ☐ No Explain: _____

Has your child ever been hospitalized? ☐ Yes ☐ No Explain: _____

_____

Is your child taking any medications? ☐ Yes ☐ No; Please list: _____

_____

Is your child allergic to any medications? ☐ Yes ☐ No Explain: _____

_____

Biological Family History

(M= mother, F= father, S= siblings, MGP= maternal grandparents, PGP= paternal grandparents)

Have any family members had the following?	**M**	**F**	**S**	**MGP**	**PGP**
1. Childhood hearing loss	☐	☐	☐	☐	☐
2. Asthma	☐	☐	☐	☐	☐
3. Tuberculosis	☐	☐	☐	☐	☐
4. Heart disease (before 55 years old)	☐	☐	☐	☐	☐

		M	F	S	MGP	PGP
5.	Bleeding disorders	☐	☐	☐	☐	☐
6.	Liver disease	☐	☐	☐	☐	☐
7.	Kidney disease	☐	☐	☐	☐	☐
8.	Epilepsy or convulsions	☐	☐	☐	☐	☐
9.	Alcohol/drug abuse	☐	☐	☐	☐	☐
10.	Diabetes/thyroid problems	☐	☐	☐	☐	☐
11.	Mental illness/depression	☐	☐	☐	☐	☐
12.	Developmental disability	☐	☐	☐	☐	☐

Past History: Does your child have or has your child ever had?

Yes	No		
☐	☐	1.	Problems with ears or hearing
☐	☐	2.	Nasal allergies
☐	☐	3.	Asthma, bronchitis, bronchiolitis, or pneumonia
☐	☐	4.	Any heart problem or heart murmur
☐	☐	5.	Anemia or bleeding problems
☐	☐	6.	Metabolic/genetic disorders
☐	☐	7.	Cancer
☐	☐	8.	Kidney disease or urologic malformations
☐	☐	9.	Sleep problems/snoring
☐	☐	10.	Chronic or recurrent skin problems (acne/eczema)
☐	☐	11.	Convulsions or other neurologic problems
☐	☐	12.	Thyroid or other endocrine problems
☐	☐	13.	History of serious injuries/fractures/concussions
☐	☐	14.	Developmental delay
☐	☐	15.	History of family violence
☐	☐	16.	(For girls) Problems with her period
☐	☐	17.	Has had her first period

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Yes	No	
☐	☐	18. Attention deficit hyperactivity disorder/anxiety, mood problems, depression
☐	☐	19. Any other significant problems

Any "yes" answers, please explain: