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**Initial History Questionnaire**

Name: \_\_\_\_\_  
ID Number: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_  
Form Completed By: \_\_\_\_\_ Date: \_\_\_\_\_

**Household**

Please List all those living in the child's home

_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems
_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems
_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems
_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems
_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems
_____ Name	_____ Relationship	_____ D.O.B.	_____ Health Problems

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

\_\_\_\_\_

If mother and father are not living together or if child does not live with parents, what is child's custody status?

\_\_\_\_\_

\_\_\_\_\_

If one or both parents are not living in the home, how often does he/she see the parent/parents not in the home?

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### **Birth History**

Birth Weight: \_\_\_\_\_ Was the baby born at term? \_\_\_ early? \_\_\_ late? \_\_\_

If early, how many weeks gestation? \_\_\_\_\_

Did mother have any illness or problem with her pregnancy? Yes / No

Explain: \_\_\_\_\_

During pregnancy did mother:

Smoke? Yes / No Drink Alcohol? Yes / No

Use drugs or medications? Yes / No

If yes, what? \_\_\_\_\_ When? \_\_\_\_\_

Was the delivery vaginal? \_\_\_ cesarean? \_\_\_

If cesarean, why? \_\_\_\_\_

Did the baby have any problems right after birth? Yes / No

Explain. \_\_\_\_\_

Was the initial feeding breast? \_\_\_ bottle? \_\_\_

Did the baby go home with mother from the hospital? Yes / No

Explain. \_\_\_\_\_

### **General**

Do you consider the child to be in good health? Yes / No

Explain. \_\_\_\_\_

Does the child have any serious illness or medical condition? Yes / No

Explain. \_\_\_\_\_

Has the child had serious injuries or accidents? Yes / No

Explain. \_\_\_\_\_

Has the child had any surgery? Yes / No

Explain. \_\_\_\_\_

Has the child ever been hospitalized? Yes / No

Explain. \_\_\_\_\_

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Is the child allergic to any medicines or drugs? Yes / No

Explain. \_\_\_\_\_

**Development**

Are you concerned about your child's physical development? Yes / No

Explain. \_\_\_\_\_

Are you concerned about your child's mental or emotional development? Yes/ No

Explain. \_\_\_\_\_

Are you concerned about your child's attention span? Yes / No

Explain. \_\_\_\_\_

How is his/her behavior in school? \_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_

Is he/she in special or resource classes? \_\_\_\_\_