Emory Johns Creek Hospital Physicians Plaza
6335 Hospital Parkway, Suite 202
Johns Creek, GA 30097

Creekview Pediatrics
caring for your child from birth to 21 yrs

Phone: (770)-622-7742
Fax: (770)-622-7743

# Initial Health History Questionnaire Page 1

**Today's Date:**_____

**Patient's last name:** _____ **First name:**_____
**Date of birth:**_____ □ **Male** □ **Female**

**Referred to Creekview Pediatrics by :**_____

## 1. List those living in the child's home

| Name | Relationship to child | Name | Relationship to child |
|---|---|---|---|
| 1._____ | | 5._____ | |
| 2._____ | | 6._____ | |
| 3._____ | | 7._____ | |
| 4._____ | | 8._____ | |

## 2. Allergies

Medications:_____ Other: _____

## 3. Household Information

Mother's name:_____ Occupation: _____
Father's name:_____ Occupation: _____
What is the child's living situation if not with both biological parents?
□ Lives with adoptive parents □ Joint custody □ Single custody □ Lives with foster family
Languages spoken in home:_____ Pets: _____
Child attends: □ Daycare □ Preschool □ Pre-K □ Elementary school □ Middle school
□ High school □ College Name of school and grade:_____
Any smokers in the household □ No □ Yes:_____

## 4. Birth History

□ Birth history unknown
Birth hospital: _____ Birth weight:_____ Weeks gestation:_____
Did mother have any illness or problems with her pregnancy: □ No □ Yes:_____
During pregnancy, did mother: Smoke □ Yes □ No Drink alcohol □ Yes □ No
Use drugs or medications: □ No □ Yes What:_____ When:_____
Was the delivery □ Vaginal □ Cesarean If cesarean, why:_____
Was a NICU stay required: □ No □ Yes, explain: _____
Did your baby go home with mother from the hospital: □ Yes □ No:_____
Was the initial feeding: □ Formula □ Breastfeeding If breastfed, how long:_____

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## Initial Health History Questionnaire Page 2

### 5. Has your child ever been hospitalized or had any of the following surgeries

□ Ear tubes □ Sinus surgery □ Tonsillectomy □ Appendectomy □ Eye surgery □ Adenoidectomy

Other: _____

Date:_____ Reason:_____ Date:_____ Reason:_____
Date:_____ Reason:_____ Date:_____ Reason:_____

### 6. Biological Family History – Check if there is family history of the condition and list who is affected

[B=brother S=sister M=mother F=father MGM=maternal grandmother MGF=maternal grandfather PGM=paternal grandmother PGF=paternal grandfather]

□ Childhood hearing loss_____
□ Nasal allergies_____
□ Asthma_____
□ Tuberculosis_____
□ High blood pressure (before 50)_____
□ High cholesterol_____
□ Anemia_____
□ Bleeding disorder_____
□ Liver disease_____
□ Cancer (before 55) _____
□ Kidney disease_____
□ Diabetes (before 50)_____
□ Bedwetting (after 10)_____
□ Epilepsy/convulsions_____
□ Drug abuse _____
□ Mental illness_____
□ Mental retardation_____
□ Immune problems, HIV, AIDS_____
□ Dental decay_____
□ Additional family history: _____

### 7. Do you consider your child to be in good health?

□ Yes □ No □ Don't Know Explain: _____

### 8. Immunizations

Up to date? □ Yes □ No □ Unsure PLEASE BRING OR FAX RECORDS

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## Initial Health History Questionnaire Page 3

**9. Please check the box if the patient has ever had:**

- □ ADHD, Inattentive
- □ ADHD, Hyperactive
- □ ADHD, Combined
- □ Allergies
- □ Anxiety
- □ Anemia or bleeding problems
- □ Any chronic skin problems (eczema, acne, etc)
- □ Any heart problems or heart murmur
- □ Asthma, bronchitis, bronchiolitis, or pneumonia
- □ Autistic disorder
- □ Bed wetting (after 5 years old)
- □ Bladder or kidney infection
- □ Blood transfusion
- □ Cancer
- □ Chickenpox
- □ Concussion
- □ Constipation requiring doctor visits
- □ Convulsions or febrile seizures
- □ Delayed milestones
- □ Dental decay
- □ Depression
- □ Diabetes
- □ (For girls) Are there problems with her periods
  Has had first period □ Yes □ No
  Age of 1st period:_____
- □ Frequent abdominal pain
- □ Frequent ear infections
- □ Frequent headaches or migraines
- □ High blood pressure
- □ History of family violence
- □ History of serious injuries or fractures
- □ HIV
- □ Malignancy/bone marrow transplant
- □ Obesity
- □ Organ transplant
- □ Pregnancy
- □ Problems with ears or hearing
- □ Problems with eyes or vision
- □ Scoliosis
- □ Sexually transmitted infections
- □ Sleep problems; snoring
- □ Speech Delay
- □ Thyroid or other endocrine problems
- □ Use of alcohol or drugs
- □ Wheezing

Any other significant problem: _____

**Form completed by:_____ Relationship to patient:_____**

**Signature: _____ Date:_____**