



**Pediatric Associates  
of Denham Springs**

Welcome Pediatric Associates of Denham Springs. We want your visit to be as pleasant as possible and encourage you to share any questions, concerns or problems you may encounter at any time. Please complete this form, sign at the bottom and give the receptionist your insurance card and driver's license to copy. You may call us back with any information you may not have with you today. Thank You!

**NEW PATIENT INFORMATION**

Child's Full Name: \_\_\_\_\_

(Please circle the name you wish us to use)

Social Security # \_\_\_\_\_ DOB \_\_\_\_\_ Race \_\_\_\_\_ Ethnicity \_\_\_\_\_

Birthplace/Hospital \_\_\_\_\_ Male \_\_\_ Female \_\_\_ Referred By: \_\_\_\_\_

Primary Pharmacy: \_\_\_\_\_ City: \_\_\_\_\_ Phone # \_\_\_\_\_

Child's Dominant Hand: Left or Right

Guarantor/Responsible Party: \_\_\_\_\_

Billing Address: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alt. Phone \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Father's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security # \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Social Security# \_\_\_\_\_

Mother's Maiden Name: \_\_\_\_\_

Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Main Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Emergency Contact Not in Household: \_\_\_\_\_ Phone: \_\_\_\_\_

Please list all other siblings (seen at this clinic) you want on this account:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**Primary Insurance:**

(Please give your primary and secondary card to the receptionist)

Insured's Name: \_\_\_\_\_ DOB: \_\_\_\_\_ SS# \_\_\_\_\_

Relation to Patient: \_\_\_\_\_ Insurance Co: \_\_\_\_\_

Insurance ID# \_\_\_\_\_ Group # \_\_\_\_\_ Ins Eff. Date \_\_\_\_\_

Deductible \$ \_\_\_\_\_ Co-pay for OV \$ \_\_\_\_\_ Co-pay for labs, shots, etc. \$ \_\_\_\_\_

***.If you do not have insurance to file payment will be due at the time of service.***

# Initial History Questionnaire

Name \_\_\_\_\_

ID NUMBER \_\_\_\_\_

BIRTH DATE \_\_\_\_\_ AGE \_\_\_\_\_

M F

FORM COMPLETED BY \_\_\_\_\_ DATE COMPLETED \_\_\_\_\_

## Household

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

Name	Relationship to child	Birth date	Health problems

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

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

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

Birth weight \_\_\_\_\_ Was the baby born at term? \_\_\_\_\_ OR \_\_\_\_\_ weeks  
 Were there any prenatal or neonatal complications?  
 Yes    No   Explain \_\_\_\_\_

Was the delivery  Vaginal    Cesarean   If cesarean, why?  
 \_\_\_\_\_

Was a NICU stay required?    Yes    No   Explain \_\_\_\_\_

Was initial feeding  Formula    Breast milk   How long breastfed? \_\_\_\_\_

During pregnancy, did mother  
 Use tobacco    Yes    No   Drink alcohol    Yes    No  
 Use drugs or medications    Yes    No    Used prenatal vitamins  
 What \_\_\_\_\_ When \_\_\_\_\_

Did your baby go home with mother from the hospital?  
 Yes    No   Explain \_\_\_\_\_

## General DK = don't know

- Do you consider your child to be in good health?    Yes    No    DK   Explain \_\_\_\_\_
- Does your child have any serious illnesses or medical conditions?    Yes    No    DK   Explain \_\_\_\_\_
- Has your child had any surgery?    Yes    No    DK   Explain \_\_\_\_\_
- Has your child ever been hospitalized?    Yes    No    DK   Explain \_\_\_\_\_
- Is your child allergic to medicine or drugs?    Yes    No    DK   Explain \_\_\_\_\_
- Do you feel your family has enough to eat?    Yes    No    DK   Explain \_\_\_\_\_

## Biological Family History DK = don't know

Have any family members had the following?

Childhood hearing loss	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Nasal allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Heart disease (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
High cholesterol/takes cholesterol medication	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Bleeding disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Dental decay	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____
Cancer (before 55 years old)	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> DK	Who _____	Comments _____

(Biological Family History continued on back side.)



## Biological Family History (Continued from front side.) DK = don't know

Liver disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Kidney disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Diabetes (before 55 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Bed-wetting (after 10 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Epilepsy or convulsions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Mental illness/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Developmental disability	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Immune problems, HIV, or AIDS	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Who _____	Comments _____
Additional family history _____					

## Past History DK = don't know

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

Chickenpox	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	When _____
Frequent ear infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with ears or hearing	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Nasal allergies	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Problems with eyes or vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Asthma, bronchitis, bronchiolitis, or pneumonia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Any heart problem or heart murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Anemia or bleeding problem	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Blood transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Organ transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Malignancy/bone marrow transplant	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent abdominal pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Constipation requiring doctor visits	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Recurrent urinary tract infections and problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Congenital cataracts/retinoblastoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Metabolic/Genetic disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Kidney disease or urologic malformations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Bed-wetting (after 5 years old)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sleep problems; snoring	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Chronic or recurrent skin problems (eg, acne, eczema)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Frequent headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Convulsions or other neurologic problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Obesity	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Thyroid or other endocrine problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of serious injuries/fractures/concussions	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Use of alcohol or drugs	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Tobacco use	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
ADHD/anxiety/mood problems/depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Developmental delay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Dental decay	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
History of family violence	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Sexually transmitted infections	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
(For girls) Problems with her periods	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> DK	Explain _____
Has had first period <input type="checkbox"/> Yes <input type="checkbox"/> No	Age of first period _____			
Any other significant problem _____				

This American Academy of Pediatrics Initial History Questionnaire is consistent with *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, 3rd Edition.

The recommendations in this publication do not indicate an exclusive course of treatment or serve as a standard of medical care. Variations, taking into account individual circumstances, may be appropriate.

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