

CHILD QUESTIONNAIRE

NAME: _____ AGE: _____ DATE OF BIRTH: _____

CHIEF COMPLAINT/CONCERN:

When was the problem first noted? _____
 Extent of problem: _____

 Previous exams and/or evaluations?: _____

FAMILY HISTORY:

Family history of:

Kidney disease	Yes	No
Thyroid problems	Yes	No
Progressive blindness	Yes	No
Previous stillbirths/miscarriages	Yes	No
Hearing loss	Yes	No
Other affected children in family	Yes	No

MATERNAL FACTORS:

Drugs (inc. antibiotics)	Yes	No
Specify: _____		
Exposure to chemicals	Yes	No
Specify _____		
Amniocentesis	Yes	No
Rh immunoglobulin given;	Yes	No
Rh or ABO incompatible		
Maternal illness during pregnancy	Yes	No
Specify: _____		
Bleeding	Yes	No
Anemia	Yes	No
Diabetes	Yes	No
Toxemia	Yes	No
Paternal illness during pregnancy	Yes	No
Specify: _____		
Mother worked outside home	Yes	No
Specify: _____		
Father worked during pregnancy	Yes	No
Specify: _____		
During pregnancy, mother was exposed to:		
Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
German Measles	Yes	No
Syphilis	Yes	No
Herpes Virus	Yes	No
Influenza	Yes	No
Cytomegalovirus (CMV)	Yes	No
Toxoplasmosis	Yes	No
Other	Yes	No
Specify: _____		

INFANT/NEWBORN FACTORS:

Small birthweight (<2 kg/5 lb)	Yes	No
Birthweight: _____		
Appar low at birth	Yes	No
In intensive care unit	Yes	No
How long: _____		
Breathing problems	Yes	No
O2 Given	Yes	No
How long: _____		
Bilirubin >15mg/100mL	Yes	No
Congenital rubella	Yes	No
Drugs (inc. antibiotics)	Yes	No
Specify: _____		
Exposure to chemicals	Yes	No
Specify: _____		
Exposure to radiation	Yes	No
Specify: _____		
Paralysis	Yes	No
Seizures	Yes	No
Septicemia	Yes	No

INFANT/CHILDHOOD HISTORY

Eye problems	Yes	No
Specify: _____		
Balance/gait/incoordination		
dizziness problems	Yes	No
Cerebral Palsy	Yes	No
Seizures	Yes	No
Head/Skull trauma	Yes	No
Hospitalized for:		
Meningitis	Yes	No
Encephalitis	Yes	No
Measles	Yes	No
Influenza	Yes	No
Rubella	Yes	No
Cytomegalovirus (CMV)	Yes	No
Chicken Pox	Yes	No
Septicemia	Yes	No
Diabetes	Yes	No
Sickle cell disease	Yes	No
Other (inc. conductive loss)	Yes	No

DELIVERY/LABOR:

Full term pregnancy	Yes	No
Labor induced	Yes	No
Labor less than 3 hours	Yes	No
Labor longer than 24 hours	Yes	No
Premature Membrane rupture	Yes	No
Bleeding	Yes	No
Forceps/Assisted delivery	Yes	No
Caesarian section	Yes	No
Other	Yes	No
Specify: _____		

Age Began: _____ Talking: _____ Walking: _____