Olathe HEALTH
Pediatrics
Olathe Medical Park

Initial History Questionnaire

Patient First Name: _____**Middle Name**: _____ **Last Name**: _____**DOB**:_____
Address: _____
Primary Physician: _____
Email: _____
Child's Sex: _____Male _____Female
Childs Race: ___Black, African American ___Asian ____White ___American Indian, Alaska Native ___Native Hawaiian, Other Pacific Islander ___Other ___Unknown ___Decline to Answer
Ethnicity: ___Hispanic or Latino ___Non-Hispanic or Latino ___Decline ___Unknown
Primary Language: _____
Best Phone # to call for appointment reminders: _____
Mother's First Name: _____ MI: _____ Last Name: _____DOB: _____
Occupation: _____ Cell Phone #: _____ Home Phone #: _____
Father's First Name: _____ MI: _____ Last Name: _____ DOB:_____
Occupation: _____ Cell Phone #: _____ Home Phone #: _____
Can we leave Personal Health Information on your cell phone number? ___Yes ____No
Can we leave Personal Health Information on your home number? ___Yes ___No

PLEASE RESPOND ONLY IF APPLICABLE: Foster Care Provider or Legal Guardian Name _____
Cell Phone Number _____ Home phone number _____

Emergency Contact First Name _____ MI _____ Last Name _____
Phone #_____
Relationship to patient _____

Please List all those living in child's home

Name	Relationship	DOB	Name	Relationship	DOB

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Birth History (if yes please explain) ##DO NOT COMPLETE IF PATIENT IS 5 YEARS OR OLDER##

Weight at Birth: _____ Discharge Weight: _____ Delivery: ___Vaginal ____C-Section Born: ___Term ___Early (____wks); ___Late (___wks)
Birth Place: ___Hospital (_____), _____Home, or ___Other(_____)
Were there any problems right after birth? ____Yes ____No * Has your child had any surgeries or hospitalizations? ____Yes ____No
Did baby go home with mother from the hospital? ____Yes ___No *Did mother have any problems with pregnancy? ____Yes ___No
During pregnancy did mother? ____Obtain pre-natal care ___Smoke ____Use drugs ___Drink Alcohol
Special Medications? _____

General Information/Development (if yes, please state what age and explain information)

Does your child have any serious illness or medical condition? ____Yes ____NO _____
Has your child had any surgeries or hospitalizations? ____Yes ____NO _____
Is your child allergic to any medicines or drugs? ____Yes _____NO _____
Are you concerned about your child's physical-mental-emotional development? ____Yes ____NO _____
Are your child's grades-attention span-behavior in school a concern for you? ___Yes ____NO _____
Has She/He failed or repeated a grade in shool? ____Yes ____NO _____

Childs past History: (Please state what age and explain information)

Does your child have, or has he/she ever had:

Chickenpox ____YES ____NO _____
Allergies (food-seasonal-latex, Asthma: ____YES ____NO _____
Frequent ear infections-problems w/hearing: ____YES ____NO _____
Problems with eyes or vision: ____YES ____NO _____
Bronchitis-bronchiolitis/RSV-pneumonia: ____YES ____NO _____
Heart problems or murmur: ____YES ____NO_____
Frequent abdominal pain: ____YES ____NO_____
Constipation requiring doctor visits: ____YES ____NO_____
Bladder/kidney infection, bedwetting>5yrs old ____YES ____NO _____
Any chronic or recurrent skin problems: ____YES ____NO_____
Frequent Headaches: ____YES ____NO_____
Convulsions or other neurologic problems: ____YES ____NO _____
Diabetes-Thyroid or endocrine problems: ____YES ____NO_____
Use of Alcohol or drugs: ____YES ____NO_____
Anemia or bleeding problems: ____YES ____NO_____
Any other significant problems: ____YES ____NO _____

Parent or Guardian Signature _____ Date: _____

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Patient name: _____ DOB: _____ Date: _____

Do any family member have any of the following conditions? (Please put an **X** under those family members that it applies to)

	Father	Mother	Brother	Sister	Maternal Grandfather	Maternal Grandmother	Paternal Grandfather	Paternal Grandmother	Explain
Asthma									
Birth Defects									
Blood Disease									
Bowel Problem									
Cancer									
Colitis									
Diabetes Mellitus									
Drug Abuse									
Ear Ache									
Epilepsy									
Food Allergy									
Headache									
Hearing Finding									
Heart Disease									
High Blood Pressure									
Kidney Disease									
Liver Disease									
Lung Disorder									
Mental Illness									
Obesity									
Scoliosis									
Seizure Disorder									
Sickle Cell Disease									
Sore Throat - Chronic									
Speech Abnormality									
Stroke									
Upper Respiratory Infection									
Ulcer									
Urinary System Finding									
Visual Impairment									

Parent or Guardian Signature: _____ Date: _____