College of Medicine – Jacksonville
Department of Pediatrics

Date of Appt:
Chronologic Age:

Hx:

Division of Developmental Pediatrics

Florida Diagnostic and Learning Resources System
Center for Autism and Related Disabilities
Developmental Pediatric Clinic

6271 St. Augustine Road, Suite 1
Jacksonville, FL 32217
(904) 633-0760

Today's Date:_____

Patient History Questionnaire

Child's Name:	Nickname:	Date of Birth:

Mother's Name		Father's Name	
Relationship	Birth Step Adoptive Foster (circle)	Relationship	Birth Step Adoptive Foster (circle)
Address (include city/zip)		Address (include city/zip)	
Home Phone (w/ area code)		Home Phone (w/ area code)	
Child's Physician		Who Referred You?	

What are your concerns about your child? (continue on next page if necessary)

Please list any medications, times and doses, taken for this problem:

Have any other agencies or professionals examined or worked with your child for this problem or any related problems? Yes ____ No ____

If Yes, please list the agencies/professionals and dates:

Dates	Agency

Additional concerns and/or comments about your child's development:

Additional concerns and/or comments about your child's development:

Please add additional pages as necessary

Pregnancy History:

Mother's age at birth		Father's age at birth	

How many total pregnancies for mother?		Which pregnancy was this one?		How much weight gained in pregnancy?	

Prenatal care began in which trimester? 1st 2nd 3rd	Did your baby have hiccups in the uterus? Yes No	Baby's movements started in which trimester? 1st 2nd 3rd
How did your baby move compared to what you expected?		

Complications During the Pregnancy: **(Please explain)**

Please check all that apply:

	Accidents		Bleeding/spotting
	Pre-term Labor		Hypertension/ edema
	Infections/rashes/flu		Prescription drugs
	Tobacco		Recreational drugs
	Alcohol		Other
	Gestational diabetes		NONE

Labor and Delivery:

Due Date:	Obstetrician:	Anesthesia: (circle) epidural spinal general IV none other
Hospital:	City, State:	
Birth Weight:	Birth Length:	Birth Head Size:
Length Labor:	Head First/Breech:	Vaginal or C-Section:
Apgars:	Forceps? Yes No	Vacuum? Yes No
	Who Held Your Baby in the Delivery Room? Mother Father other family no family (medical staff only)	

Other Problems: NONE

Complications in Delivery Room? NONE

Did your baby require any resuscitation in the delivery room? What type NONE

Neonatal History:

How long did your baby stay in the hospital? 1day 2 days 3days other: (how long?)

Was your baby in an NICU? Yes No How long? Level II (how long?) Level III (how long?)

Was oxygen required? Yes No How long? NONE Was a ventilator required? Yes No How long? NONE

Other Nursery Complications: **(Please explain)**

Please check all that apply:

	NONE		Feeding Problems:
	Jaundice & Phototherapy:		Infections:
	Temperature Problems:		Blood sugar problems:
	Discharge medications:		Congenital abnormalities:
	Discharge with Oxygen:		NONE

Other Nursery Problems:

Infancy History:

Please check all that apply:

	Typical		Good Natured
	Especially quiet and good		Difficult
	Hyperactive		Colic
	Feeding Problems		Chronic Reflux
	Tongue thrusting		Frequent vomiting & weight loss
	Notable stiff tone		Notable low tone
	Arched from cuddling		Routine medications required

Other Problems during Infancy:

Please explain all yes marks:

Past Medical History:

Primary Care Source:	Private Practitioner Clinic Emergency Room
Date of Last Medical Care or Check Up and reason:	

Other Medical Sources Utilized	Pediatrics FP ENT Ortho Ophtho Dental Other
Source	**Who** (where, when and in what capacity)

Previous hospitalizations:
(date, age, reason, length?)

Previous surgeries: Circumcision?
(date, age, reason, length?)

Previous fractures:

Previous sutures:

Previous ingestions:

Current medical diagnoses:
(age and whom made Dx)

Other previous medical diagnoses:
(age and whom made Dx)

Current (regular) medications:
(include name/time/dates/strength)
(include all OTC and "natural" treatments)

Previous (regular) medications: (include name/time/dates/strength)

Drug allergies:
(Include side effects)

Food allergies:
(Include side effects)

Diet History: Regular for age? Yes No Restricted: (please specify) Other: (please specify)

Are immunizations up-to-date?	Yes No	Which are delayed?	Why?

Review of Systems:
Has your child ever had any of the following problems in any of the following areas? Please ***circle any appropriate***. Please ***add any other problems*** which are not listed:

General:	excessive weight loss	excessive weight gain	unexplained fevers	
Neurologic:	seizures	frequent unbreakable staring spells	involuntary movements	
	vocal tics	motor tics	frequent headaches	"hypotonia"
Head:	been knocked unconscious	previous head MRI, CT and/or ultrasound		
Eyes:	ROP	been tested for glasses	cataracts	glaucoma
	strabismus	esotropias	"lazy eye"	amblyopia	nystagmus
	neonatal conjunctivitis	corneal clouding		diplopia
Ears:	Previous Hearing Test(s):	Age: ____	Result: ____	
		Age: ____	Result: ____	
	acted deaf	chronic ear infections	ear tubes	
Nose:	history of allergy problems	frequent nose bleeds	frequent sinus problems	
Throat/dental:	cavities/dental problems	prolonged bottle use	feeding difficulties	
	restricted diet	frequent gagging/choking	chewing clothes	
	mouthing objects	eating dirt	oral surgery	cleft lip/cleft palate
Neck:	torticollis	goiter	neck stiffness	unexplained lymphadenopathy
	chronic neck stiffness			
Cardiovascular:	unexplained murmurs	congenital heart disease	palpitations	
	hypertension	cyanosis	exercise intolerance	
	excessive sweating during feedings as an infant			
Respiratory:	asthma	frequent pneumonias	frequent bronchitis	TB
	chronic night coughing	history of apnea and/or bradycardia		
Gastrointestinal:	chronic constipation	frequent soiling underwear	stopping up toilet	
	frequent vomiting	frequent/chronic diarrhea	chronic stomach pains	
Genitourinary:	delayed toilet training	urinary tract infections	circumcised	
	bed wetting after 5 years old	undescended testicle	hypospadias	
	bladder/kidney problems	painful or bloody urination		
Hematologic:	anemia	thalassemia	sickle cell disease	no prior lead test
	abnormal prior lead test	easy and frequent bruising		
Orthopaedic:	any problems with bones. Joints, nerves or muscles			
	history of muscle weakness			

Dermatologic:	problems with dry and/or ashy skin	birth marks
	irregular pigmentation, light or dark	unusual rashes
Endocrine:	diabetes excessive water drinking	excessive urination
	thyroid disease excessively short/tall stature	
	premature or excessively delayed puberty	
Psychiatric:	**Sleep Problems:**	**Emotional problems**:
	excessive sleeping	impulsivity
	trouble getting to sleep	significant behavior problems
	trouble staying asleep	oppositional behaviors
	nightmares	alcohol/drug use
	night terrors	tantrums
	sleep walk/talk	depression
	sleep with parents	

Family/Social History:

Mother		**Father**	
Name:		Name:	
Age:		Age:	
Employment:		Employment:	
Education Level:		Education Level:	
High School Academics:	Good Fair Poor	High School Academics:	Good Fair Poor
High School Behavior:	Good Fair Poor	High School Behavior:	Good Fair Poor
Any help with reading or speech therapy	Yes No	Any help with reading or speech therapy	Yes No
Reads for Pleasure:	Yes No	Reads for Pleasure:	Yes No
Medical History:		Medical History:	
Marriage History:	Length of 1st:	Marriage History:	Length of 1st:
	Length of 2nd:		Length of 2nd:
	Length of 3rd:		Length of 3rd:

Siblings:

Name	**Age**	**How related** (full, ½ , step)	**Grade**	**Medical Problems**	**Behavior Problems**	**Academic or Developmental Problems**

Step-Mother		**Step-Father**	
Name:		Name:	
Age:		Age:	
Employment:		Employment:	
Education Level:		Education Level:	
High School Academics:	Good Fair Poor	High School Academics:	Good Fair Poor
High School Behavior:	Good Fair Poor	High School Behavior:	Good Fair Poor
Any help with reading or speech therapy	Yes No	Any help with reading or speech therapy	Yes No
Reads for Pleasure:	Yes No	Reads for Pleasure:	Yes No
Medical History:		Medical History:	
Marriage History:	Length of 1st:	Marriage History:	Length of 1st:
	Length of 2nd:		Length of 2nd:
	Length of 3rd:		Length of 3rd:

Does any one in either family have similar problems to your child? Yes No
If so, who, and how are they related and how are the problems similar?

Please check all that apply:

	Yes?	Who (include which side)		Yes?	Who (include which side)
School problems:			AD/HD:		
Learning Disabilities:			Autistic Spectrum Disorders:		
Blind/Deaf Infants:			Depression:		
Vision Problems: (not from old age)			Hearing Problems: (not from old age)		
Diabetes:			Frequent miscarriages:		
Seizures:			Cancer:		
Thyroid:			Heart disease:		
Hypertension:			Stroke:		
Renal:			Alcoholism:		
Mental Retardation:			Mental Illness:		
Other family medical concerns:			Other family medical concerns:		

Is there any chance the natural mother and natural father are related outside marriage? Yes No

The level of stress in the home for MOTHER is ___ out of 10
The level of stress in the marriage for the MOTHER is ___ out of 10

The level of stress in the home for FATHER is ___ out of 10
The level of stress in the marriage for the FATHER is ___ out of 10

Is there enough money to pay the bills each month? Yes No

Additional stressors include:

Is tobacco used by anyone living in the home? Yes No Who? How much?

Please list any pets:

Neurodevelopmental History:

Who is completing this form?

At what age did you first become concerned about your child's development?:

What first concerned you about your child's development?

What is your child's best ability or strength?

What skill causes your child the most difficulty or challenge?

In your child's overall behavior, how ***old does he/she act*** like they are?
Mother's response: Father's response:

Has your child ever lost any skills or abilities? Yes No
What was lost?

Behavior History:

Please describe your child's behavior:

Who is your child's best friend?

What is the friend's age?

What are your child's favorite activities?

How does your child behave for other adults?:
Better than w/ you? The same as w/you? Worse than w/you?

Please check any of the following which apply to your child, now or in the past:

	Knows car routes at a young age		Spins for prolonged periods of time		Hypnotized by ceiling fans
	Plays with light switches for prolonged periods of time		Constantly plays in running tap water		Plays with doors as a toy, or have to have all doors open or shut
	Upset if house or room organization is altered		Rocks for comfort		Constantly flushes toilets as a toy
	"flaps hands when excited or happy		Has significant trouble with transitions		Follows rigid routines for comfort
	Enjoys lining up objects		Upset if lined items are changed		Acts deaf when playing with things
	Significant head banging when angry		Bites self to draw blood when angry		Pulls out pieces of hair when angry
	Aggressive with other children		Stealing		Setting or playing with fires
	Shy around strangers		Hurts animals intentionally to cause pain		Trouble with eye contact
	Excessive Laughing		Excessive Crying		Excessive Jealousy
	Frequent and chronic temper tantrums		Feelings Easily Hurt		Excessively Suspicious
	Frequent Toe Walking		Bed Wetting		Excessive Dependence
	Skipping school		Masturbates		Chronic lying
	High pain tolerance		Trouble with sleep		Masturbates
	Doesn't share enjoyable events and objects with parent		Oppositional with adult rules and requests		Fails to come to parent for comfort when hurt
	Other:				

Who disciplines your child?
How do you discipline your child?

Are you afraid to walk in a parking lot without holding your child's hand? Yes No

If Yes: Why?

When your child goes to other children's birthday parties, what does he/she do when the other child is opening presents?

Is your child able to wait in line for a reasonable time if it is for something he/she has anticipated? Even if something less desirable is available immediately?

Do your child's emotions fluctuate easily and quickly? Yes No

Educational History:

Current School:		County:	
Address:		Phone Number:	
Contact:		Teacher:	
Grade:		Type of Class:	Regular ESE: Type:
Pull-out or Resource Room?		Any Mainstreaming:	Yes No

Are there specific problems at school?

Does your child have an IEP or FSP? Yes No

Service	**How frequently**	**How long/session**	**Individual or group**
Speech Therapy			
Occupational Therapy			
Physical Therapy			
Early Intervention			

Previous educational experiences:

Dates	Ages	School/ISD	Grade/Class type	Academic Concerns	Behavior Problems

Any other Issues not addressed?

Please write the age (IN MONTHS) that your child attained the following milestones ***for all that are known to you.***

Gross Motor History:

Skill	**Age**	**Skill**	**Age**
Lift head from table		Bear weight on wrist	
Roll stomach → back		Roll back → stomach	
Sit if placed there		Sit unassisted	
Combat crawl		Hand-knee crawl	
Pull to stand		Cruise	
Walk independently		Walk stairs- hand held by parent	
Walk stairs using rail		Kick a ball	
Change feet going up stairs		Change feet going down stairs	
Pedal a trike		Skip	
Ride 2 wheel bike **without** training wheels			

Fine Motor/Adaptive History:

Skill	**Age**	**Skill**	**Age**
Unfisted > 50% of time		Intentionally reach to grab things	
Transfer between hands		Pincer for small things	
Finger feed		Weaned to a cup	
Use a spoon alone		Use a fork as a fork	
Scribble with a crayon		Move a zipper up/down	
Unsnap		Toilet trained	
Pull pants up over rear of diaper		Unbutton alone without pulling	
Get shoes on feet alone		Button alone	
Get shoes on correct feet		Draw a circle	
Get completely dressed w/o help		Draws a square	
Knows Left and Right		Draws a triangle	
Ties shoes			
Can tell time on a clock (not digital)			

Is your child	Right Handed	Left Handed	at what age?

Has your child ever experienced:

Drooling when not teething?	Yes	No	Frequent vomiting with weight loss?	Yes	No
Tongue thrusting	Yes	No	Gagging/Choking with Textures?	Yes	No

Expressive Language History:

Skill	Age	Skill	Age
Coo with vowels		Laugh	
"Ah-Goo"		Make raspberries	
Babble consonant strings		Use "mama/dada" as a general word	
Reach for things to indicate a want		Use "mama/dada" ***only for parent***	
Point for things wanted		First word: NOT a name	
Uses 10-15 spontaneous words		Put two words together (not "hot dog" or "thank you")	
Uses 50 spontaneous words		Mom understood 100% of words (no more jargoning)	
Used 3 word sentences		Used correct pronouns	
Asked "WH" questions		Could tell about day in 3-4 sentences	

Receptive Language History:

Skill	Age	Skill	Age
Smiled intentionally for mother		Found mother in a room by voice	
Find others in a room by voice		Wave "bye-bye" spontaneously	
Understood "no" as word, not a tone		Could follow a "give" command	
Could follow "bring me" command when out of sight		Repeated sounds back to you	
Knew 1st Body Part <u>on own face</u>		Knew several body parts on own face	
Could follow 2 different commands at the same time		Knew primary colors (red/yellow/blue)	
Knew his/her gender		Understood "big/little"	
Knew own phone number		Recognized all letters of alphabet **<u>by sight</u>**	
Could write own name			