NC Child Health Program Initial History Questionnaire *(created 7/1/2012)*

Patient Name: | Date of Birth: | Sex: (Circle) Male Female

Person Who Filled Out Form: Date Filled Out: | Relationship to Patient:

PREGNANCY AND BIRTH HISTORY

Is the child adopted? No Yes
Birth Weight: _____ pounds _____ ounces
Was baby born on time? No Yes _____ weeks
Was the birth Vaginal C-Section If C-Section, Why?_____
_____
Were there any problems during the pregnancy or at birth?
No Yes If yes, explain: _____
_____
During pregnancy did mom:
Use tobacco? No Yes Drink alcohol? No Yes
Use drugs or other medications? No Yes What: _____
Use prenatal vitamins? No Yes When:_____
Did baby have problems or need to stay in a NICU?
No Yes If yes, explain: _____
The initial feeding for the baby was: Formula Breast milk
How long did the baby breastfeed? _____
Did the baby go home with mom? No Yes
If no, explain: _____

HOUSEHOLD

List names, relationships to child, and ages of all people living with the child:
_____
_____
_____
Are there siblings not listed? If so, list names, ages and where they live:
_____
_____
What is your child's living situation?

Joint custody Single custody Foster care

If one or both parents are not living in the home, how often does the child see the parent not in the home?
_____
Tobacco use in family? No Yes Who?: _____

CHILD'S HEALTH HISTORY

Has the **child** ever had:

Hospitalizations	No	Yes
Serious Injuries/Broken Bones	No	Yes
Surgeries	No	Yes
Allergies To Medications/Other: _____	No	Yes
Chicken Pox (Year) _____	No	Yes
Frequent Ear Infections	No	Yes
Vision/Hearing Problems	No	Yes
Nasal Allergies	No	Yes
Asthma /Lung Problems	No	Yes
Tuberculosis(TB)/Risks for TB	No	Yes
Any Heart Problems/Murmur	No	Yes
Anemia/Sickle Cell	No	Yes
Bleeding Problems/Transfusion	No	Yes
Immune Problems/HIV	No	Yes
Cancer	No	Yes
Stomach Aches/Constipation	No	Yes
Bladder Infections/Kidney Disease	No	Yes
Birth Defects	No	Yes
Metabolic/Genetic Conditions	No	Yes
Sleep/Snoring/Bed Wetting Issues	No	Yes
Chronic Skin Problems/Eczema	No	Yes
Frequent Headaches	No	Yes
Seizures/Neurological Problems	No	Yes
Obesity	No	Yes
Diabetes	No	Yes
Thyroid/Endocrine Problems	No	Yes
High Blood Pressure	No	Yes
Alcohol/Drug Use/Tobacco	No	Yes
ADHD/Anxiety/Mood/Depression	No	Yes
Developmental Delay/Disability	No	Yes
Dental Decay/Cavities	No	Yes
History of Family Violence/Abuse	No	Yes
Sexual Infections/Pregnancy	No	Yes
Elevated Lead Level	No	Yes
Other: _____	No	Yes

BIOLOGICAL FAMILY HEALTH HISTORY

Has anyone in **the family of the child** (parents, grandparents, sisters/brothers) had:

			Who?
Childhood Hearing Loss	No	Yes	_____
Nasal Allergies	No	Yes	_____
Asthma	No	Yes	_____
Tuberculosis (TB)/Risks for Tuberculosis	No	Yes	_____
Lung Problems	No	Yes	_____
Heart Disease	No	Yes	_____
High Blood Pressure/Stroke	No	Yes	_____
High Cholesterol/Takes Cholesterol Medication	No	Yes	_____
Anemia/Sickle Cell ¬	No	Yes	_____
Bleeding Problems	No	Yes	_____
Dental Decay (cavities)	No	Yes	_____
Cancer	No	Yes	_____
Liver Disease/Hepatitis	No	Yes	_____
Kidney Disease	No	Yes	_____
Diabetes (high blood sugar)	No	Yes	_____
Obesity	No	Yes	_____
Seizures/Epilepsy	No	Yes	_____
Alcohol Abuse	No	Yes	_____
Drug Abuse ¬	No	Yes	_____
Mental Illness/Depression	No	Yes	_____
Development Delay/Disability	No	Yes	_____
Immune Problems/HIV/AIDS	No	Yes	_____
Other Family History: _____	No	Yes	_____

Additional Comments:

NC Child Health Program - Cuestionario de Historial Medico

Nombre del Paciente:		Fecha de Nacimiento:	Sexo: M (Masculino) (circule) F (Femenino)
Persona que llenó el formulario:	Fecha Completado:	Relación con el Paciente:	

HISTORIAL DURANTE EMBARAZO Y AL NACER

¿Es el niño/a adoptado? No Sí
Peso al nacer: _____ libras _____ onzas
¿El bebé nació a tiempo? No Sí _____ semanas
¿El parto fue Vaginal? Cesárea?
¿Si tuvo cesárea, porque razón? _____
¿Hubo alguna complicación durante el embarazo o al bebé nacer?
No Sí Si respondió sí, explique: _____
_____
Durante el embarazo, la mama:
¿Usó tabaco? No Sí Tomó alcohol? No Sí
¿Usó drogas o medicamentos? No Sí ¿Cuáles? _____
¿Usó vitaminas prenatales? No Sí ¿Cuando?:_____
¿Tuvo algunos problemas o necesidad de que el bebé se quedara en la unidad de cuidados intensivo?: No Sí
Si respondió sí, explique: _____
La alimentación inicial fue: Formula Leche materna
¿Cuánto duró tomando el pecho?: _____
¿Su bebé se fue del hospital a la casa junto con la madre?
No Sí Si no, explique: _____

HISTORIAL DEL HOGAR

Mencione a todos los que vivan en el hogar del niño/a, y las relaciones/ el parentesco con el niño/a y sus edades.
_____
_____
¿Hay hermanos/as que no fueron mencionados? Si es así, escriba sus nombres, edades, y dónde viven :
_____
_____
¿Con quien vive el niño/a?
Esta en custodia con ambos padres
Esta en custodia individual con solo padre o madre
Vive con una familia asignada por ley (Foster Care)

Si uno o ambos padres no viven en casa, ¿con que frecuencia ve el niño/a al padre/madre que no esta en la casa?
_____
¿Usan tabaco en su familia? No Sí
¿Quién(es)?: _____

HISTORIAL DE SALUD DEL **NIÑO/A**

Alguna vez, **su niño/a** ha tenido/ha sido:

Hospitalizado	No	Sí
Algunas heridas graves/ Fracturas	No	Sí
Alguna Cirugía	No	Sí
Alergias a Medicamentos/ u Otras Cosas Médicas:_____	No	Sí
Varicela (año): _____	No	Sí
Infecciones de Oídos Frecuentes	No	Sí
Problemas de Audición o de Visión	No	Sí
Alergias Nasales	No	Sí
Asma/Enfermedad del Pulmones	No	Sí
Tuberculosis/Riesgos de Tuberculosis	No	Sí
Algún Problema de Corazón/ Soplo en el Corazón	No	Sí
Anemia/Anemia Drepanocítica (Sickle Cell)	No	Sí
Trastornos Sanguíneos o Hemorrágicos	No	Sí
Problemas Inmunológicos/VIH o SIDA	No	Sí
Cáncer	No	Sí
Dolor Abdominal Frecuente/Estreñimiento	No	Sí
Recurrente Infección en las Vías Urinarias /Enfermedad Renal--de los Riñones	No	Sí
Defectos de Nacimiento	No	Sí
Trastornos Metabólicos/Genéticos	No	Sí
Problemas para Dormir/Ronquido /Orinarse en la Cama	No	Sí
Problemas Crónicas de la Piel /Eczema	No	Sí
Dolores de Cabeza Frecuentes	No	Sí
Convulsiones/Otros Problemas Neurológicos	No	Sí
Obesidad	No	Sí
Diabetes (azúcar en la sangre)	No	Sí
Tiroides/Otros Problemas Endocrino	No	Sí
Alta Presión Sanguínea	No	Sí
Uso de Alcohol o Drogas/Uso de Tabaco	No	Sí
Déficit de Atención/Ansiedad/Depresión	No	Sí
Retraso en el Desarrollo/Discapacitado	No	Sí
Caries Dentales	No	Sí
Historial de Violencia Familiar/Abuso	No	Sí
Infecciones de Transmisión Sexual/Embarazo	No	Sí
Nivel alto de plomo	No	Sí
Otras:_____	No	Sí
	No	Sí
	No	Sí

HISTORIAL DE SALUD DE LA **FAMILIA BIOLÓGICA**

Hay alguien **en la familia** del niño (padres, abuelos, hermanos/as) que hayan tenido:

			¿Quién?
Perdida de la Audición en la Infancia	No	Si	_____
Alergias nasales	No	Si	_____
Asma	No	Si	_____
Tuberculosis/Riesgos de Tuberculosis	No	Si	_____
Enfermedad del Pulmones	No	Si	_____
Enfermedad del Corazón	No	Si	_____
Alta Presión Sanguínea/Ataque cerebral	No	Si	_____
Colesterol Alto/Toma Medicina para el Colesterol	No	Sí	_____
Anemia/Anemia Drepanocítica (Sickle Cell)	No	Sí	_____
Trastornos Sanguíneos o Hemorrágicos	No	Sí	_____
Caries Dentales	No	Sí	_____
Cáncer	No	Sí	_____
Enfermedad del Hígado/Hepatitis	No	Sí	_____
Enfermedad de los Riñones	No	Sí	_____
Diabetes (azúcar en la sangre)	No	Sí	_____
Obesidad	No	Sí	_____
Epilepsia/Convulsiones	No	Sí	_____
Abuso de Alcohol/Drogas	No	Sí	_____
Enfermedad Mental/Depresión	No	Sí	_____
Retraso en el Desarrollo/Discapacitado	No	Sí	_____
Problemas Inmunológicos /VIH o SIDA	No	Sí	_____
Otro historial familiar: _____	No	Sí	_____

Comentarios adicionales:

Directions for use of the Child Health Initial History Form

The new Child Health Program Initial History form is available for implementation beginning August 1, 2012 in conjunction with the Bright Futures Tool and Resource Kit forms. The form is available for download and printing at http://ncdhhs.gov/dph/wch/lhd/cyforms.htm.

Background

This form is made available by the Child Health Program based on feedback from local agencies regarding the length, organization, and difficulty with local health department clients using the Initial History Questionnaire form provided in the Bright Futures Tool and Resource Kit. Agencies may use the new Child Health Program Initial History form or continue to use the Initial History Questionnaire Form in the Bright Futures Tool and Resource Kit. Local policies must indicate which form that the agency is using, the date of implementation if using the new form, and quality assurance processes to assure the chosen form is used consistently and in the manner specified in the policy and procedure.

The Bright Futures (BF) Pilot agencies have tested the form and provided feedback for revisions to the final document. The form has been designed for completion by the parent or teen with English and Spanish versions on the same form to allow efficient review by clinicians who do not speak Spanish. The Spanish version has been reviewed by Branch staff for accuracy.

Implementation

The agency must establish a date for implementation and begin using the form with new patient visits. Children who have a Bright Futures Initial History Questionnaire form in the chart do not require a new form. **This means that if there is already a BF Initial History Questionnaire form in the chart, you do not need to complete and replace it with a new Child Health Program Initial History Form.**

We have tried to format the form to allow for placement of a sticker in the top right hand corner. In some instances the label used in the agency may cover the date of birth and sex of the child, however, this information is on the label. There is room for brief notes by the clinician if clarification or comment is needed for any of the answers provided by the parent or youth on the Initial History form. At future visits when updates are needed to the Initial History, the Child Health Program recommends use of the Updates to the Initial History form which is available at http://ncdhhs.gov/dph/wch/lhd/cyforms.htm.

Local policy must establish the form that is used, and include guidance about completion and the accountability for review and use of the data in the overall assessment of the child or youth.

Quality Assurance

The Health Check Billing Guide requires a comprehensive health history on the initial visit with updates at subsequent visits. To meet this requirement, the Child Health Program provides the following guidance.

- **An Initial History form must be completed once on all clients**. The Initial History assesses the biological family medical history, the child's medical and social history. The Initial History also assesses for the presence of issues related to several body systems (i.e., recurrent ear infections, frequent headaches).
- **A documentation of a review (and update if indicated) of the Initial History form must be done at each visit.** Documentation must indicate that there are no changes since the last visit OR indicate the specific changes in the child's medical history, social or family history, and review of systems information. An update to the review of systems information includes reviewing the questions asked in the Initial History about body systems (i.e., headaches, vision or hearing problems) AND addressing the information in the review of systems section (for children under 11 years of age) or HEADSSS section (for children 11 years of age and older) on the Bright Futures Visit Documentation form. The information on the pre-visit questionnaire must also be reviewed and used to help with documenting additional concerns, questions or changes provided by the person completing the form in the medical, social, or family history and any additional issues that are related to the review of systems information for infant, child or adolescent. The Child Health Program has made available an Updates to the Initial History form that may be used to document changes to the Initial History at subsequent visits.