GEORGETOWN UNIVERSITY CHILDREN'S MEDICAL CENTER
DEPARTMENT OF PEDIATRICS - DIVISION OF CHILD NEUROLOGY

~ Twelve Months – Two Years ~
DEVELOPMENTAL PEDIATRIC (TODDLER) HISTORY QUESTIONNAIRE

Toddler's Name ____ Today's Date ________________

Age _____________ months Child's Date of Birth ____________________

Child's Parent/Caregiver(s) __________________________ Home Phone ______________________
Work Phone ______________________

Person Completing Questionnaire ____
Please list your questions or concerns ____
____
____

When did you first become concerned? ____
What is/was it that first caused you to become concerned? _______________________________________
____
____

Does your child have any additional medical problems? (Please describe briefly, then send or bring with you any relevant records/reports, if available.) ____
____
____

Has your toddler been evaluated by the Infants & Toddlers Program for any reason? Yes No
If Yes, where? (Name and Address of Program): ________________________________
____
____

Does your child have an (Check the one which applies)
____ Individualized Family Service Plan {I.F.S.P.}?
____ Other (private treatment program)?
Is a copy of it available?Yes* No

What special and/or related services, if any, is your baby/toddler receiving? _______________________
(Please describe if needed) ____
____

*Please bring copies of the most recent reports, IFSP, and any applicable/related information with you to the appointment for evaluation.

Has your child had a Speech and Language evaluation?
Please detail ____
____

Has your child had a Pediatric Developmental evaluation? Yes No
Please detail: ____
____

PAST MEDICAL HISTORY

How long was the pregnancy with your baby? _____Full term(Born within 2 weeks of date due) _____Born Premature at _____ weeks

Was your labor induced or augmented? How and Why? ________________________________

____

____

How long was your labor? ____

How was your baby delivered? _____ Normal vaginal delivery

_____ Were forceps or vacuum used? (If yes, circle which one)

_____ C-section Why?______________________________

____

____

Was your baby born/delivered ___ Head (vertex) ____ Buttocks or ____ Feet (Breech) first?

Did you have any problems right after birth (Please describe)? ___________________________

____

Were there any problems (complications) immediately after birth with your baby? Yes No

____ Jaundice, ____ Rh factor (Did you receive a Rhogam shot? Yes No), ____ Fever,

____ Infection, _____ Use of incubator, _____ Cyanosis (blue baby)

Did your baby need oxygen? Why? ____

What type/How was it given? ____

____

How long were you in the hospital after delivery? _____________________________________

How long was your baby in the hospital after delivery? _________________________________

Was your baby in the NICU (Neonatal Intensive Care Unit) Yes No

If Yes, how long? ____

Why? ____

Was your baby on a ventilator and if so how long? _________________________________

____

Was your baby on CPAP and if so how long? _____________________________________

Did your baby need surgery during that time (When, What and Why)? ______________

____

During the pregnancy (check all that apply and give details where applicable):

Did you smoke? _________ ppd. During the ___ First ___ Second ___ Third Trimester

Did you drink alcohol? ___ First ___ Second ___ Third Trimester

What and how much? ______________________________________

How much drug use did you partake in? ___ First ___ Second ___ Third Trimester

What and how much? ______________________________________

Did you have any bleeding? ___ First ___ Second ___ Third Trimester

Why and how much? ______________________________________

Did you sustain any trauma to your abdomen (i.e., fall, motor vehicle accident)? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Did you have any fevers or illness? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Did you require any antibiotic treatments? ___ First ___ Second ___ Third Trimester

___ ___ ___

Please detail briefly ____

____

Did you have high blood pressure? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Did you have diabetes? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Did you have pre-eclampsia or toxemia? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Were you on bedrest at any time? ___ First ___ Second ___ Third Trimester

If so, why and for how long? ____

____

Did you require any other medical treatment during the pregnancy? ___ First ___ Second ___ Third Trimester

Please detail briefly ____

____

Once you felt your child move inside was there any period greater than 24 hours when you did not feel him/her move? ____

____

____

____

____

If you have other children, how did the activity of this baby compare with the other babies? ______ More ______Less ______Same ______Not Applicable

Has/Does your child had/have any of the following? (If so, please describe and give age in months at the time of the problem. If extensive, please use area provided at the end of the questionnaire.):

_________ Major illnesses requiring prolonged medication

_________ Hospitalizations

_________ Operations/Surgery

_________ Head Injuries (any loss of consciousness, prolonged dizziness, vomiting afterward or headaches?)

_________ Fits, Seizures, Convulsions

_________ Infections of the Nervous System (meningitis, encephalitis)

_________ Lead or other poisoning: Has this been check? Yes No

What was the Level? ____________________

What treatment was done (if any)? ____________________

_________ Has your child eaten/drunk any non-food items? (If so what and at what age?

____

Has/Does your child had/have any of the following? (If so, please describe and give age in months at the time of the problem.)

__________ Vision Problems: If applicable, has this been checked?
__________ Hearing Problems: If applicable, has this been checked?
__________ Frequent (multiple times in first year of life) ear infections (Otitis media) needing antibiotics. Were PE tubes placed? Yes No. If yes,when?__________________
__________ Growth or Weight Problems
__________ Feeding or Failure to Thrive Problems
__________ Allergic reactions
__________ Allergies (to medications or others) ____
____
__________ Are your child's immunizations (shots) up to date (if infant is old enough)?
If not, which are needed? ____

Have any of the following tests been performed (Check and indicate or send results):

Blood Tests: _____ Ammonia _____Lactate _____ Pyruvate _____Serum Amino Acids
_____ Lead level _____Thyroid Function
Urine Tests: _____ Metabolic Screen _____Organic Acids Amino Acids
Genetic Testing: _____ Chromosomes _____ Fragile X (DNA)
Magnetic Resonance Imaging (MRI) of the Brain: ______________________________________
Electroencephalogram (EEG) ____
BrainStem Auditory Evoked Potential (BAER): _______________________________________
Cortical Auditory Evoked Potential (CAER): ____
Echocardiogram (ECHO): ____
Any other testing not listed here: ____
____
____
____
____

DEVELOPMENTAL HISTORY

Does your child have any major fears? Yes No
If yes, please describe briefly: ____
____

Does/Did your baby like cuddling or being held? ______________________________________
If yes, please describe briefly: ____
____

Is/Was your baby excessively restless or irritable? ____________________________________
If yes, please describe briefly: ____
____

Please answer all applicable items. Remember not all babies/toddlers develop at the same rate.

How old was your baby when he/she first: GROSS MOTOR	Actual or Age	Approximate Age	Relative to Siblings slower faster same
Sat up on their own	________	___ <9 mos. <	_____ ______________
Crawled (how/type) ______________	________	___ <10 mos.<	_____ ______________
Stood alone	________	___ <13 mos.<	_____ ______________
Walked alone	________	___ <16 mos.<	_____ ______________
Ran (toddler type)	________	___ <18 mos.<	_____ ______________

LANGUAGE/SOCIAL			
Smiled	________	___ < 2 mos. <	_____ ______________
Cooed	________	___ <2-3 mos.<	_____ ______________
Babbled	________	___ <4-6 mos.<	_____ ______________
Said first words	________	___ < 7 mos. <	_____ ______________
Understandable single words	________	___ < 9 mos. <	_____ ______________
Spoke in a two word phrase	________	___ < 2 yrs. <	_____ ______________
Spoke in full sentences	________	___ < 3 yrs. <	_____ ______________

How old was your child when he/she first: FINE MOTOR/ADAPTIVE	Actual or Age	Approximate Age	Relative to Siblings slower faster same
Grasped rattle	________	___ <2-4 mos <	_____ ______________
Reached for object	________	___ <3-5 mos <	_____ ______________
Passed toy from hand to hand	________	___ <5-8 mos <	_____ ______________
Held object between thumb & finger	________	___<7- 10 mos<	____ ______________
Drank from a cup	________	___<10-14 mos<	____ ______________
Scribble spontaneously	________	___<~16 mos <	____ ______________
Could use a spoon spilling little	________	___<14-20 mos<	___ ______________
Washed & dried hands	________	___ <19-24 mos<	___ ______________
Pulled on own clothes	________	___ <21-24 mos<	___ ______________

Does/did your toddler/baby have any difficulty with (Please heck if Yes and when):

_____ Separating from parent(s)? ____

_____ Toilet training? ____

If accomplished, when for Bladder? ____

Bowel? ____

Is your toddler in ________________ Day Care? What type ____

At what age did they start in day care? ____

What are your child's main (favorite play) interests? ____

____

REVIEW OF SYSTEMS

Does your toddler have any other Health Problems? If yes, please describe including when symptoms started and any medical treatments: ____

____

____

Has your child ever lost any skills that they previously had (i.e., language regression, that is, gained a developmental milestone then completely lost that ability)? Yes No

If so, what skills? ______________________________

At what month of age? ______________________________

Over what period of time? ______________________________

Regressed to what extent (i.e., partial or complete loss)? ______________________________

Please detail briefly ______________________________

____

Has your child ever had a seizure (fit, epilepsy, convulsions)? ______________________________

Please detail ______________________________

____

____

Has your child ever had staring spells when you had difficulty getting their attention? ______________

Please detail ______________________________

____

Has/Does your child ever had/have a motor tic (a sudden contraction of a muscle group, a flinch, or habit) or vocal tic (involuntary repetitive sound)?______________________________

____

____

Does your child have any repetitive behaviors (i.e., hand flapping, head banging, rocking, walking in circles)? ______________________________

Is your child bothered by things (stimuli) that do not seem to bother other people or yourself (i.e., sounds, bright lights, certain clothing or the labels on pants and shirts, being touched, certain textures of food)?

Yes No

(Please describe briefly)______________________________

____

____

Does your child sleep well? Yes No

Usual bedtime: ______________________________

Usual wake time: ______________________________

Nap(s) from when to when: ______________________________

If your baby is old enough do you have a regular bedtime routine? (Please describe briefly) ____

____

____

Does your toddler eat well? Yes No

On what type of schedule? ______________________________

What formula do you use, if any? Similac Enfamil Prosobee Isomil SMA

Other ______________________________

Did your baby have colic? Yes No

If yes, from when to when? ______________________________

____

Does your baby: Spit up regularly?

Throw up (vomit)?

Does it shoot across the room or just “come out”?

What medicines, treatments, or interventions have been used? (Please detail date, duration, benefits, etc.):

____
____
____
____
____
____

FAMILY/SOCIAL HISTORY

Family Educational History (Please complete all information known even if the child does not reside with their biological parents):

Name	Age	Highest Grade Completed in School	Occupation/Work/School
Mother			
Father			
Siblings			

Whom does your child resemble most in the family? ______________________________

Below are listed some things that run in families. Please circle the biological family members who show these and describe briefly:

KEY TO FAMILY ABBREVIATIONS:
P-Father/Paternal (on the father's side of the family)
M=Mother/Maternal (on the mother's side of the family)
A=Aunt U=Uncle First Cousin=Children of parent's brothers or sisters)
MU=Maternal Uncle (mother's brother) MA=Maternal Aunt (mother's sister)
PU=Paternal Uncle (father's brother) PA=Paternal Aunt (father's sister)
PGM=Paternal Grandmother (father's mother) PGF=Paternal Grandfather (father's father)
MGM=Maternal Grandmother (mother's mother)
MGF=Maternal Grandfather (mother's father)

Left-Handers:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins (Distinguish between Maternal or Paternal)
Please Describe: ____
____

Attentional/Organizational/Executive Function Difficulties:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins (Distinguish between Maternal or Paternal)
Please Describe: ____
____

Specific Learning Disabilities, Dyslexia, Slow Readers, Bad Math Students:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please Describe: ____
____

Speech and Language difficulties, Communication difficulties, Pervasive Developmental Disorder, Autism, Asperger's Syndrome:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal and Paternal
Please Describe: ____
____

Fine Motor Difficulties, Poor Handwriting, Difficulty Handling Utensils:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please Describe: ____
____

Gross Motor Difficulties, Cerebral Palsy, Delayed Walking, Clumsy:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please Describe: ____
____

Global Developmental Delay, Mental Retardation, Genetic Disorders (Down Syndrome, Fragile X):
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please Describe: ____
____

Seizures, Fits, Epilepsy, Convulsions:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Migraine Headaches:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Neurological Brain Disorders (i.e., Stroke under the age of 40 years):
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Any Early Childhood Deaths of Unknown Cause:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Auto immune Disease (Diseases such as lupus, long names ending in --itis):
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Juvenile forms of Diabetes or Rheumatoid Arthritis:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Disorders of the Glands, Endocrine System, Thyroid Problems:
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Allergies (i.e., Hayfever, Eczema, Asthma):
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____

Psychiatric Problems (i.e., Depression, Anxiety, Schizophrenia, Obsessive Compulsive Disorder):
Child Biological Siblings Father(P) Mother(M)
Child's Aunts(A) and Uncles(U) MU MA PU PA
Child's Grandparents(G): PGM PGF MGM MGF
Child's First Cousins Distinguish between Maternal or Paternal
Please describe: ____
____
____
____
____

Any Additional Comments Concerning the Family History:
____
____
____
____
____
____

Any Additional Comments or Information not addressed in this questionnaire:
____
____
____
____
____

Name of Child's Pediatrician:	
Physician's Telephone No. and Fax No.	
Physician's Address:	