INITIAL HISTORY — RESTON PEDIATRICS

Patient's Name_____ Sex: Male Female DOB___/___/___

Form completed by_____ Relation to Patient_____ Date___/___/___

FAMILY HISTORY

Are mother and father ☐ married ☐ unmarried ☐ separated/divorced

What is the child's living situation if not with both biological parents?

☐ Single custody ☐ Joint custody

☐ Lives with adoptive family ☐ Lives with foster family

If one or both parents are not living in the home, how often does the child see that parent(s)?_____

_____

_____

Are there siblings living away from home? ☐ Yes ☐ No

If yes, name, age, where they live?_____

List all family members living in the patient's home

Name	Relation	Date of Birth	Health Problems

CURRENT MEDICAL HISTORY

Do you consider your child to be in good health? ☐ Yes ☐ No

If no, please explain: _____

Are immunizations up to date? ☐ Yes ☐ No

Current Medications:_____

_____

Drug Allergies? ☐ Yes ☐ No If yes, please explain with reaction (if known):_____

_____

Food Allergies? ☐ Yes ☐ No If yes, please explain with reaction (if known):_____

_____

REVIEW OF SYSTEMS & PAST MEDICAL HISTORY

DK = don't know

Does the patient currently have or ever had the following (please specify where applicable)

Frequent abdominal pain	☐ Yes	☐ No	☐ DK	Explain_____
Acne, eczema, other recurring skin problems	☐ Yes	☐ No	☐ DK	Explain_____
Use of alcohol, drugs, tobacco	☐ Yes	☐ No	☐ DK	Explain_____
ADHD, anxiety, depression, mood disorders	☐ Yes	☐ No	☐ DK	Explain_____
Anemia, blood transfusion, bleeding disorder	☐ Yes	☐ No	☐ DK	Explain_____
Asthma, bronchitis, respiratory infections	☐ Yes	☐ No	☐ DK	Explain_____
Bed-wetting after 5yrs-old	☐ Yes	☐ No	☐ DK	Explain_____
Cancer	☐ Yes	☐ No	☐ DK	Explain_____
Chickenpox	☐ Yes	☐ No	☐ DK	Explain_____
Constipation requiring doctor's visits	☐ Yes	☐ No	☐ DK	Explain_____
Convulsions or other neurologic problems	☐ Yes	☐ No	☐ DK	Explain_____
Diabetes	☐ Yes	☐ No	☐ DK	Explain_____
Frequent ear infections, tubes, hearing problem	☐ Yes	☐ No	☐ DK	Explain_____
Eye/vision problems	☐ Yes	☐ No	☐ DK	Explain_____
Hospitalization or surgery (please give dates, reasons)	☐ Yes	☐ No	☐ DK	Explain_____
Frequent headaches	☐ Yes	☐ No	☐ DK	Explain_____
Heart murmur or other cardiac problems	☐ Yes	☐ No	☐ DK	Explain_____
High blood pressure	☐ Yes	☐ No	☐ DK	Explain_____
Serious injury/accident, fracture, concussion	☐ Yes	☐ No	☐ DK	Explain_____
Kidney disease, urologic malformation	☐ Yes	☐ No	☐ DK	Explain_____
Metabolic or genetic disorders	☐ Yes	☐ No	☐ DK	Explain_____
Seasonal allergies	☐ Yes	☐ No	☐ DK	Explain_____
Thyroid or other endocrine problems	☐ Yes	☐ No	☐ DK	Explain_____
Recurrent urinary tract infections	☐ Yes	☐ No	☐ DK	Explain_____
(For females) Problems with her periods	☐ Yes	☐ No	☐ DK	Explain_____

Has had first period ☐ Yes ☐ No Age of first period _____

Any other significant problem_____

_____

CONTINUED ON BACK

DEVELOPMENT

Are you concerned about the patient's….
Physical development? ☐ Yes ☐ No Explain_____
Mental or emotional development? ☐ Yes ☐ No Explain_____
Learning ability? ☐ Yes ☐ No Explain_____
Attention span or activity level? ☐ Yes ☐ No Explain_____
If in school, has the patient had…
Tutoring outside of the classroom? ☐ Yes ☐ No Explain_____
Placement in a special or resource class? ☐ Yes ☐ No Explain_____
To repeat a grade? ☐ Yes ☐ No Explain_____
Educational or psychological testing? ☐ Yes ☐ No Explain_____
Behavioral problems? ☐ Yes ☐ No Explain_____

MATERNAL AND NEWBORN HISTORY ☐ Don't know birth history

Pregnancy
Did mother smoke, use recreation drugs or alcohol? ☐ Yes ☐ No _____
Did mother take prenatal vitamins? ☐ Yes ☐ No _____
Check if the mother had any of the following problems:
☐ excessive weight gain ☐ urinary infections ☐ excessive swelling ☐ toxemia ☐ rubella ☐ venereal disease ☐other ☐ none
_____

Birth
Birth Weight_____ Length_____Apgar_____ Was baby born at: ☐ Term ☐ Early ☐ Late _____weeks gestation
Was labor difficult or prolonged? ☐ Yes ☐ No _____
Was delivery difficult or prolonged? ☐ Yes ☐ No _____
Was a NICU stay required? ☐ Yes ☐ No Was the delivery ☐ vaginal ☐ Cesarean If Cesarean, why? _____

Newborn
Was initial feeding ☐ Formula Type _____ ☐ Breast milk How long breastfed? _____
Did the baby go home with mother from the hospital? ☐ Yes ☐ No _____
Check if patient has/had any of the following problems:
☐ feeding problems ☐ multiple formula changes ☐ recurring diarrhea ☐other_____
☐ slow weight gain ☐ recurring vomiting ☐ colic ☐ jaundice

BIOLOGICAL FAMILY HISTORY DK = don't know

If a family member has or has had any of the following problems, check the appropriate box and list the family member:
M-Mother F-Father S-Sibling MA-Maternal Aunt MU-Maternal Uncle PA-Paternal Aunt PU-Paternal Uncle
PGM-Paternal Grandmother PGF-Paternal Grandfather MGM-Maternal Grandmother MGF-Maternal Grandfather

Alcohol/Drug abuse	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Allergies/Drug allergies	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Anemia/Blood disorders	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Asthma	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
ADD/Learning problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Behavioral/Emotional problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Cancer(please specify)	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Childhood hearing loss/Deafness	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Depression/Mental illness	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Diabetes	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Ear infections/Tubes	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Eczema	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Endocrine problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Epilepsy/Neurologic problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Eye or visual problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Genetic disorders	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
High cholesterol	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
High blood pressure	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Immunity problems/HIV	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Kidney/bladder problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Liver disease	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Mental retardation	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Myocardial infarction(heart attack)	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Obesity	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Other relevant medical problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Respiratory infections	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Stomach/GI problems	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Stroke (brain attack)	☐ Yes	☐ No	☐ DK	Who_____	Comments_____
Tuberculosis	☐ Yes	☐ No	☐ DK	Who_____	Comments_____

Other relevant family history_____
_____