HISTORY UPDATE

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

Has the patient had any of the following in the last year(please specify where applicable):

Condition	Yes	No	DK	Explain
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 5-yrs old	☐ Yes	☐ No	☐ DK	Explain________________________
Cancer	☐ Yes	☐ No	☐ DK	Explain________________________
Chickenpox	☐ Yes	☐ No	☐ DK	Explain________________________
Constipation requiring doctor visits	☐ Yes	☐ No	☐ DK	Explain________________________
Convulsions or other neurologic problem	☐ Yes	☐ No	☐ DK	Explain________________________
Diabetes	☐ Yes	☐ No	☐ DK	Explain________________________
Frequent ear infections, tubes, hearing problem	☐ Yes	☐ No	☐ DK	Explain________________________
Eye/vision problem	☐ 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 problem	☐ Yes	☐ No	☐ DK	Explain________________________
High blood pressure	☐ Yes	☐ No	☐ DK	Explain________________________
High cholesterol	☐ Yes	☐ No	☐ DK	Explain________________________
Serious injury/accident, fracture, concussion	☐ Yes	☐ No	☐ DK	Explain________________________
Kidney disease, urologic malformation	☐ Yes	☐ No	☐ DK	Explain________________________
Metabolic or genetic disorder	☐ 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________________________
ADHD/anxiety/mood problems/depression	☐ 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________________________________

Biological Family History DK = don't know

If a family member currently has or has ever had any of the following problems, please check the appropriate box and list the family member. Please specify condition where applicable.

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

Condition	Yes	No	DK	Who	Comments
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 blood pressure	☐ Yes	☐ No	☐ DK	Who__________	Comments__________
High cholesterol	☐ Yes	☐ No	☐ DK	Who__________	Comments__________
Immunity problems/HIV	☐ Yes	☐ No	☐ DK	Who__________	Comments__________
Kidney/Bladder problem	☐ 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__________
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 ____

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