INITIAL HISTORY — RESTON PEDIATRICS

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

Form completed by_____ Relation to Patient_____ Date___/___/___

FAMILY HISTORY

Are parents ☐ 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