Pediatric Specialists of Virginia | Children's National | Inova Children's

NEW PATIENT FORM

DATE: _____

PATIENT NAME: _____

DATE OF BIRTH: _____

SCHOOL ATTENDING: _____

PRIMARY CARE PHYSICIAN: _____

REFERRING PHYSICIAN: _____

Reason for today's visit: _____

Describe the problem: _____

MEDICAL HISTORY (please list any medical problems)

_____ _____ _____

_____ _____ _____

HOSPITALIZATIONS

Age	Problem	Dates

SURGICAL HISTORY (please list any previous surgeries including dates)

_____ _____ _____

_____ _____ _____

MEDICATIONS ☐ None

Drug Name	Dose (amount)	Frequency (how often)	Scheduled	As needed
			☐	☐
			☐	☐
			☐	☐
			☐	☐

ALLERGIES ☐ None

Substance	Reaction	Severity (please circle)		
		Mild	Moderate	Severe
		Mild	Moderate	Severe
		Mild	Moderate	Severe

IMMUNIZATIONS Up to date: ☐ Yes ☐ No

Please fill out front and back of this form.

BIRTH HISTORY

Full Term ☐ YES ☐ NO

If premature, born at (weeks) _____

Pregnancy complications ☐ YES ☐ NO

Explain: _____

Delivery complications ☐ YES ☐ NO

Explain: _____

Birth weight: _____

DEVELOPMENTAL HISTORY

Motor Delays ☐ YES ☐ NO

Speech Delays ☐ YES ☐ NO

Age when started walking: _____

For female patients:

Age at first menses: _____

Last menses: _____

SOCIAL HISTORY

Smoking in the home ☐ YES ☐ NO

Lives with parent/guardian ☐ YES ☐ NO

FAMILY HISTORY

Please note any disorders that run in the family

☐ NONE

medical problem	Mother		Father		Sister		Brother		Aunt		Uncle		Cousin	

REVIEW OF SYSTEMS (Please check any symptoms that you have had recently) ☐ALL NEGATIVE

Constitutional	☐NONE ☐activity change ☐appetite change ☐chills ☐diaphoresis (sweats) ☐fatigue ☐fever ☐unexpected weight loss ☐other:
Eyes	☐NONE ☐eye discharge ☐eye itching ☐eye pain ☐eye redness ☐photophobia (light sensitivity) ☐visual disturbance ☐other:
Endocrine	☐NONE ☐heat/cold intolerance ☐polydipsia (increased thirst) ☐polyphagia (excessive eating) ☐polyuria (excessive urination) ☐other:
Allergic/Immunologic	☐NONE ☐environmental allergies ☐ food allergies ☐immunocompromised ☐other:
Ears/Nose	☐NONE ☐congestion ☐dental problem ☐drooling ☐ear discharge ☐ear pain ☐facial swelling ☐hearing loss ☐mouth sores ☐nose bleeds ☐postnasal drip ☐rhinorrhea (running nose) ☐sinus pain ☐sinus pressure ☐sneezing ☐sore throat ☐tinnitus (ringing in ear) ☐trouble swallowing ☐voice change ☐other:
Respiratory	☐NONE ☐apnea (stop breathing) ☐chest tightness ☐choking ☐cough ☐shortness of breath ☐stridor ☐wheezing ☐other:
Genitourinary	☐NONE ☐difficulty urinating ☐dysuria (painful urination) ☐enuresis (bed wetting) ☐flank pain ☐frequency ☐hematuria (blood in urine) ☐pelvic pain ☐urgency ☐other:
Neurologic	☐NONE ☐dizziness ☐headache ☐lightheadedness ☐numbness ☐seizures ☐speech difficulty ☐tremors ☐weakness ☐other:
Cardiovascular	☐NONE ☐chest pain ☐leg swelling ☐palpitations ☐other:
Hematologic	☐NONE ☐adenopathy (swollen lymph nodes) ☐bruises/bleeds easily ☐other:
Gastrointestinal	☐NONE ☐abdominal distension ☐abdominal pain ☐blood in stool ☐constipation ☐ diarrhea ☐nausea ☐vomiting ☐other:
Psychiatric	☐NONE ☐agitation ☐behavior problem ☐confusion ☐decreased concentration ☐dysphoric mood (unhappy) ☐hallucinations ☐hyperactive ☐nervous/anxious ☐self-injury ☐sleep disturbance ☐other:
Skin	☐NONE ☐color change ☐pallor (pale skin) ☐rash ☐wound ☐other:

Person completing form: _____

Relationship to patient: _____

Date & Time completed: _____