Children's National™

NEW PATIENT FORM

DATE: ________
PATIENT NAME: ____________________
DATE OF BIRTH: ____________________
SCHOOL ATTENDING: ________________

PRIMARY CARE PHYSICIAN: ____________________
REFERRING PHYSICIAN: __________________________
Located in (please circle): DC MD VA

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

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

Alcohol in the home ☐ YES ☐ NO

Live with legal guardian ☐ YES ☐ NO

Family History

Please note any disorders that run in the family

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 ☐fever ☐chills ☐fatigue ☐unexpected weight loss ☐other:
Eyes	☐NONE ☐blurred vision ☐double vision ☐drainage ☐reddened eye ☐other:
Ears/Nose	☐NONE ☐difficult swallowing ☐nose bleeds ☐earaches ☐other:
Cardiovascular	☐NONE ☐chest pain ☐palpitations ☐fainting ☐other:
Respiratory	☐NONE ☐cough ☐snoring ☐difficulty breathing at rest ☐difficulty breathing with activity ☐shortness of breath ☐other:
Gastrointestinal	☐NONE ☐nausea ☐vomiting ☐constipation ☐diarrhea ☐heartburn ☐other:
Genitourinary	☐NONE ☐bed wetting ☐bloody urine ☐frequency ☐incontinence ☐urgency ☐other:
Musculoskeletal	☐NONE ☐joint pain ☐joint swelling ☐instability of joints ☐stiffness ☐back pain ☐other:
Skin	☐NONE ☐redness ☐skin color change ☐itching ☐rash ☐ulcers/lesions ☐other:
Neurologic	☐NONE ☐headache ☐confusion/disorientation ☐dizziness ☐numbness ☐tingling ☐weakness ☐other:
Psychiatric	☐NONE ☐nervousness ☐anxiety ☐depression ☐hallucinations ☐other:
Hematologic	☐NONE ☐easy bruising ☐excessive bleeding ☐other:
Endocrine	☐NONE ☐increased thirst ☐heat/cold intolerance ☐other:
Allergic/Immunologic	☐NONE ☐reaction to food ☐environmental allergies ☐multiple infections ☐other:

Person completing form: ______________________

Relationship to patient: ______________________

Date & Time completed: ______________