FNA Fairfax Neonatal Associates, PC a Neonatal & Pediatric Subspecialty Group
Pediatric and Adolescent Sleep Center
AASM ACCREDITED Facility Member™
2730-D Prosperity Avenue | Fairfax, VA 22031
19465 Deerfield Avenue, Suite 410 | Leesburg, VA 20176
T. 703.226.2290 | F. 703.226.2291
www.fnapc.com/pasc

New Patient Medical History

Name:_____ **DOB**:_____ **Age**:_____ **Date**:_____

Person filling out form:_____ **Relationship to Patient**:_____

Referring Provider:_____

Other physicians to receive report, and their fax#(s):_____

Main reason for visit today:_____

Past Medical History (Please circle the appropriate response)

Birth History: Full Term Premature (# of weeks:_____)

Hospitalizations: None Dates and reasons: _____

Surgeries: None Tonsillectomy (Date: _____) Adenoidectomy (Date: _____) Ear tubes (Date: _____)

Other (Date: _____) Describe:_____

Allergies to Medications: No Yes Describe:_____

Environmental Allergies: No Yes Describe:_____

Food Allergies: No Yes Describe:_____

Immunizations: Up To Date Not Up to Date

Current Medications / Supplements (Please write amount, how often, and write if taken only "as needed")

☐ **Not currently taking any medications**

Name	Strength / Dose	Frequency (how often)

Other therapies: (Please circle and write settings if applicable)

CPAP:_____BiPAP:_____Oxygen:_____Ventilator:_____Other:_____

Family History (Please X all columns that apply)

	Mother	Father	Sibling 1	Sibling 2	Sibling 3	Sibling 4
Healthy						
Deceased						
Snoring						
Obstructive sleep apnea						
CPAP or BiPAP use						
Overweight						
Insomnia						
Restless Leg Syndrome						
Narcolepsy						
Thyroid disease						
Other:						

Environment and Social History (Please fill or circle the appropriate response)

Language in home	English	Spanish	Other:	
Lives with	Biological mother	Adoptive mother	Stepmother	Foster mother
	Biological father	Adoptive father	Stepfather	Foster father
	Brother(s)	Sister(s)	Grandmother(s)	Grandfather(s)
	Other:			
Biological parents	Married	Never married	Divorced	Separated
School Grades	Good	Average	Failing	
Smoke exposure	No Yes	Does the patient smoke?	No	Yes

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New Patient Medical History - Page 2 of 2

Patient Name: _____ Date _____

Review of Systems (Please circle the correct responses)

General Health	Good Sleepy Always tired	**Appetite**: Good Poor	**Weight**: Normal Under Over
Skin	Normal Eczema Dry Itching at night		
Eyes	Normal Glasses Contacts Visual Impairment		
Ears, Nose, Throat	Normal Ear infections Hearing loss Stuffy nose Runny nose Post-nasal drip Sinusitis Mouth breathing Large adenoids Large tonsils Frequent strep throat		
Neck	Normal Stiffness Swollen Glands Tracheostomy		
Respiratory	Normal Asthma Cough Wheezing Shortness of breath		
Cardiovascular	Normal Murmur Congenital Heart Defect Heart failure Fainting Hypertension		
Gastrointestinal	Normal Diarrhea Constipation Vomiting Heartburn Spits up GE Reflux G-tube		
Genitourinary	Normal Bedwetting Painful urination Bladder infection		
Musculoskeletal	Normal Scoliosis Back pain Arthritis		
Neurological	Normal Headaches Seizures Weakness Developmental Delay Hypotonia		
Psychiatric/Behavioral	Normal Depression Anxiety ADHD ADD Autism Behavior problems		
Endocrine	Normal Diabetes Hypothyroidism		
Hematology	Normal Anemia Immunodeficiency		
Genetics	Normal Other:		
Other Problems:			

Thank you for completing this form so that we can provide comprehensive care to your child.