FNA Fairfax Neonatal Associates, P.C. a Neonatal & Pediatric Subspecialty Group
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Interval History Form

General Information

Name: _____ **DOB:** _____ **Age**: _____ **Date**: _____
Person filling out form: _____ **Relationship to Patient**: _____
Referring Physician: _____
Other physicians to receive report, and their fax #s: _____
Reasons for visit today: _____
Since the last visit, is the patient's sleep (circle one): Better Unchanged /Stable Worse

Medical events since the last visit

Illnesses: No Yes Dates/Describe:
Hospitalizations/Operations: No Yes Dates/Reason:
Allergies to Medications: 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** □**No changes to medications since last visit**

Name	Strength / Dose	Frequency (how often)

Other therapies: (Please circle and write settings if applicable)
CPAP:_____ BiPAP:_____ Oxygen:_____ Ventilator:_____ Other:_____

Review of Systems (Please circle the correct responses)

□**No changes since last visit**

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
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:							

Family Medical History

□**No changes since last visit** ***Changes since last visit:*** _____

Environment and Social History *(Please circle the appropriate response)*

□**No changes since last visit**	
Any change in family members living at home? No Yes If yes, describe:	
School Grades: Good Average Failing	
Smoke exposure: No Yes	Does the patient smoke? No Yes