Pediatric Specialists of Virginia

Children's National INOVA

Pediatric Specialists of Virginia Genetics

Patient Intake Form

Instructions Allow yourself at least an hour of uninterrupted quiet time to complete this packet. Be sure you complete this packet in its entirety. Please do not leave any blanks. If something does not apply, please write N/A. If you do not know the answer, please write unsure.

Date form completed _____

Patient Name _____

First Middle Last

Date of Birth _____ Age _____ Sex _____

Name of person completing this form _____

Relation to patient _____

Please provide best contact information _____

Phone _____ Email _____

Primary Care Provider

Name _____

Office Location _____ Phone number _____

Referring Provider (if different than your primary care provider)

Name _____ Specialty _____

Office Location _____ Phone number _____

What is the reason for your visit today?

_____

_____

_____

_____

_____

_____

Has the child been evaluated by a Geneticist in the past? ☐ Yes ☐ No

If yes, name of clinic and date _____

Has the child ever had genetic testing? ☐ No ☐ Yes. If yes, please send a copy of all genetic testing to Genetics@psvcare.org

If yes and you do not have a copy of previous testing results, please provide contact information for facility where it was performed. _____

Patient Identification

If label is not available, please complete:

Patient Name _____

DOB: _____ MR# _____

Revised May 2, 2019

Child's Medical History

Child's Current Medications

Please include any over the counter medication, creams drops and lotions. Please include dose and how often it is taken.

_____
_____
_____
_____
_____

Has the child ever stayed overnight in the hospital? ☐ No ☐ Yes If yes, please indicate why, how long and where.

_____
_____

Please list all the Doctors that the child currently sees or has ever seen in the past.

Provider's Specialty	Provider's Name	Location	Date Last Seen	Diagnosis or Surgery
Genetics (prior to today's appointment)				
Cardiology (Heart doctor)				
Dermatology (Skin doctor)				
Endocrinology (Hormone doctor)				
ENT/otolaryngology (Ear, Nose & Throat)				
Gastroenterology (GI doctor)				
Neurology or Neurosurgery				
Urology				
Nephrology / Renal (Kidney doctor)				
Ophthalmology or Optometry (Eyes/vision)				
Orthopedic surgery (Bone doctor)				
Pulmonology (Lung doctor)				
Psychology/Psychiatry				
Other specialist(s):				

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Please list any additional diagnoses or symptoms not indicated above.

Symptom or diagnosis	Age (or date) of onset / diagnosis	Additional comments

Please list any lab testing, radiology imaging or surgical procedures that have been performed.

Test Name	Location	Results (if known)

Birth History of Child ☐ Unknown, child adopted

Name of Hospital of birth _____ State _____

Birth Weight _____Birth Length _____

Was the baby full term, 36 weeks or greater? ☐ Yes ☐ No If no, how many weeks early? _____

Type of delivery ☐ Vaginal ☐ Breech ☐ Caesarean, please provide the reason_____

Did the patient experience any problems following birth? ☐ No ☐ Yes If yes, please provide details_____

_____

How many days did your child stay in the hospital after birth? _____

Child's Social History

Child's biological parents

Please check all that apply

☐ In a relationship ☐ Married ☐ Divorced

☐ Live together ☐ Live separately ☐ Mother has no contact with patient ☐ Father has no contact with patient

☐ Patient is Adopted Does patient know they are adopted? ☐ Yes ☐ No

☐ Biological parents unknown ☐ Biological parent known

☐ Has contact with biological family ☐ No contact with biological family

Child's Biological Mother ☐ Unknown

Name _____ Age _____

What is the mother's ethnicity? *Check all that apply*

☐ Caucasian ☐ African American ☐ Asian ☐ Middle Eastern ☐ Jewish

☐ Hispanic ☐ Native American ☐ Other_____

Level of Education_____

Occupation _____

How often does child see mother? _____

Does the mother have custody of the child?

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Child's Biological Father ☐ Unknown

Name _____ Age _____

What is the father's ethnicity? *Check all that apply*

☐ Caucasian ☐ African American ☐ Asian ☐ Middle Eastern ☐ Jewish

☐ Hispanic ☐ Native American ☐ Other_____

Level of Education_____

Occupation _____

How often does child see father? _____

Does the father have custody of the child? _____

Other than the child's parents, who lives in the home with this child? Please list all persons living in the home, their age, and their relation to the child. If parents live separately and child lives in both house, please indicate occupants for both houses. Please be sure to provide our registration staff with a copy of any applicable custody paperwork.

_____

_____

_____

Pregnancy History of Child's Biological Mother ☐ Unknown, child adopted

How old was the child's mother at time of pregnancy? _____ How old was the child's father at time of pregnancy? _____

Was the child conceived with the assistance of reproductive technology such as IUI, IVF, donor egg or sperm, or surrogacy?

☐ No ☐ Yes If yes, please indicate which one._____

How many months pregnant was the child's mother when she first saw a doctor?_____

Please list any prescription medications and illicit drugs taken by the child's mother BEFORE pregnancy.

_____

Please list any over the counter, prescription medications and illicit drugs taken by the child's patient's mother DURING pregnancy? _____

Did the mother of the child use any cigarettes or other nicotine products DURING pregnancy? ☐ No ☐ Yes If yes, please indict which ones._____

Did the mother of the child drink any alcohol DURING pregnancy? ☐ No ☐ Yes If yes, please indict which how much and how often._____

Did the mother of the child have any medical problems during the pregnancy or with any pregnancies in the past?

☐ No ☐ Yes If yes, please list all medical problems (Including gestational diabetes, hypertension, fevers, abnormalities on ultrasounds)_____

_____

Did the mother have any Genetic testing during pregnancy? ☐ No ☐ Yes If yes, please indicate the results in the table below.

TEST	RESULT
Parental Carrier Testing	
Non-invasive Prenatal Screening (cell free DNA)	
CVS – Chorionic Villi Sampling	
Amniocentesis	

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Patient's Development

When did your child first? Please provide the age in months or years to the best of your ability in the table below.

Gross Motor Skill	Age	Fine Motor Skill	Age
Sit		Pincer grasp	
Crawl		Point	
Walk		Eat with utensils	
Run/climb		Scribble	
Throw a ball		Write Name	
Ride a tricycle			
Social/Communication Skills		Adaptive Skills	
Wave 'bye bye'		Help with dressing	
Babble		Use buttons	
First word		Potty trained	
Putting 2 word sentences together			

Patient Education

Name of Current School_____ Grade_____

Does your child have an Individualized Education Plan? (IEP) ☐ No ☐ Yes If yes, briefly describe services and therapies that your child receives at school. _____

_____

Does your child receive any therapy services outside of school? ☐ No ☐ Yes If yes, please Indicate how often.

Speech Therapy_____ Occupational Therapy_____ Physical Therapy_____

Please list any blood related family members with medical problems including Genetic disorders, intellectual disability, seizures, and birth defects.

Relation to Child	Symptom/Diagnosis

Please list any additional information or comments that you think are important for your provider to know. Use additional pages as needed.

_____

_____

_____

_____

_____

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