Children's National Medical Center, Washington, DC
Division of Urology Ambulatory Treatment Record
Family Questionnaire, Page 1 of 2

[Put Patient Name Sticker Here]

PATIENT INFORMATION	Child's First Name:	Child's Date of Birth:
Child's Sex: ☐ Male ☐ Female	Child's Last Name:	Child's Age:

What is the reason for today's visit?

Describe the problem and how long it has been happening:

What other concerns do you have?

BIRTH HISTORY

Were there any problems during pregnancy? ☐ No ☐ Yes
Was your child full term? ☐ No ☐ Yes
If not full term at how many weeks was child delivered? _____
How much did your child weigh at birth? _____
Were there any problems during labor or delivery? ☐ No ☐ Yes
Did the mother and child go home together? ☐ No ☐ Yes
If didn't go home together, how long did child stay? _____
Did the child have breathing problems? ☐ No ☐ Yes

PRIOR HOSPITALIZATIONS AND SURGERIES

Has your child been hospitalized or had surgery? ☐ No ☐ Yes If yes, list them below, most recent first; if more than 3 specify number _____

Age	Problem (reason for hospitalization or surgery)	Hospital Name	Hospitalization or Surgery Dates

Has your child received blood transfusions? ☐ No ☐ Yes ☐ Unsure
Are your child's immunizations up to date? ☐ No ☐ Yes ☐ Unsure

MEDICATION HISTORY AND RECONCILIATION

Does your child have allergies to any medicines? ☐ No ☐ Yes ☐ Unsure If yes, which ones?
Does your child have allergies to anything breathed in? ☐ No ☐ Yes ☐ Unsure If yes, which ones?
Does your child have allergies to any foods? ☐ No ☐ Yes ☐ Unsure If yes, which ones?

Is your child currently taking any prescription, over the counter, or herbal medicines? ☐ No ☐ Yes ☐ Unsure If yes, list them below.

What is the name of the medicine? (one per row)	How much of this medicine is taken per dose?	How many times a day is this medicine taken?	When was the last time this medicine was taken?	What does this medicine treat?

Please continue answering questions on the back.

[ATR Form Version 04/2013]

Children's National Medical Center, Washington, DC Division of Urology Ambulatory Treatment Record Family Questionnaire, Page 2 of 2	*[Put Patient Name Sticker Here]*

MEDICATION HISTORY AND RECONCILIATION Continued from previous page.

What is the name of the medicine? (one per row)	How much of this medicine is taken per dose?	How many times a day is this medicine taken?	When was the last time this medicine was taken?	What does this medicine treat?

FAMILY HISTORY List illnesses present in your child's family members.

Bleeding Problems	☐ No ☐ Yes	Which family members?
Kidney Stones	☐ No ☐ Yes	Which family members?
Urinary Tract Infections	☐ No ☐ Yes	Which family members?
Kidney Failure	☐ No ☐ Yes	Which family members?
Diabetes	☐ No ☐ Yes	Which family members?
High Blood Pressure	☐ No ☐ Yes	Which family members?

SOCIAL HISTORY

Are you the child's legal guardian?	☐ No ☐ Yes If no, list legal guardian's name: Please provide court order if guardian is not natural parent.
What grade is the child currently in?	Grade: _____ ☐ Not In School
What is the child's performance in school?	☐ Excellent ☐ Good ☐ Fair ☐ Poor
Has the child traveled outside the country?	☐ No ☐ Yes
Is the child exposed to tobacco smoke?	☐ No ☐ Yes

REVIEW OF SYMPTOMS Check all symptoms that your child has.

General	No	Yes	**Heart**	No	Yes	**Ear, Nose, Throat**	No	Yes	**Joints**	No	Yes
Fever	☐	☐	High Blood Pressure	☐	☐	Ear Infections	☐	☐	Scoliosis	☐	☐
Tiredness	☐	☐	Heart Murmur	☐	☐	Sinus Problems	☐	☐	Joint Pain	☐	☐
Skin	No	Yes	**Lungs**	No	Yes	**Nerves**	No	Yes	**Stomach / Intestines**	No	Yes
Eczema	☐	☐	Wheezing/Cough	☐	☐	Seizures	☐	☐	Vomiting / Nausea	☐	☐
Rashes	☐	☐	History of Asthma	☐	☐	Developmental Delay	☐	☐	Abdominal Pain	☐	☐
Hormone / Endocrine	No	Yes	**Eye**	No	Yes	Headache or Migraines	☐	☐	Feeding Problems	☐	☐
Diabetes	☐	☐	Vision Problems	☐	☐	Autism	☐	☐	Constipation	☐	☐
High Cholesterol	☐	☐				ADHD Attention Deficit	☐	☐	Stool Accidents	☐	☐

Name of Person Completing Form _____ Date & Time Form Completed _____

Relationship to Patient _____

[ATR Form Version 04/2013]