

ADHD MEDICAL HISTORY

Name _____ DOB _____ Age _____ Date _____

What is your concern? _____

Circle areas of concern:

health problem	risk taking	unhappy at school	test taking	speech
absenteeism	peer relations	motor skills	homework	reading
motivation	immaturity	attention	completing work	writing
disobedience	self-esteem	distractibility	copying from board	spelling
inappropriate sounds	anger control	inconsistent performance	retaining information	math
inappropriate movements	hyperactivity	disruptive behavior		

Current School: _____ **Grade:** _____ **Class size:** _____

Teacher: _____ **When did problems begin?** _____

<input type="checkbox"/> Y	<input type="checkbox"/> N	Has child been retained? What grade? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Has child had IEP/504 evaluation?
<input type="checkbox"/> Y	<input type="checkbox"/> N	Special education classes? What classes? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Currently tutored? What classes? _____

Past Medical History:

<input type="checkbox"/> Y	<input type="checkbox"/> N	Chronic illness? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Previously diagnosed ADHD? When? _____ By whom? _____ Any medicines tried? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Currently taking medication? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Heart defect/heart problems? _____

Has your child ever had the following?

<input type="checkbox"/> Y	<input type="checkbox"/> N	head injury	<input type="checkbox"/> Y	<input type="checkbox"/> N	near-drowning
<input type="checkbox"/> Y	<input type="checkbox"/> N	seizures	<input type="checkbox"/> Y	<input type="checkbox"/> N	headaches
<input type="checkbox"/> Y	<input type="checkbox"/> N	meningitis or encephalitis	<input type="checkbox"/> Y	<input type="checkbox"/> N	stomachaches
<input type="checkbox"/> Y	<input type="checkbox"/> N	tics/repetitive movement	<input type="checkbox"/> Y	<input type="checkbox"/> N	vision problem
<input type="checkbox"/> Y	<input type="checkbox"/> N	poisoning	<input type="checkbox"/> Y	<input type="checkbox"/> N	hearing problem

Birth History:

<input type="checkbox"/> Y	<input type="checkbox"/> N	Did the mother have problems with the pregnancy? What were they? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Use of recreational drugs or alcohol during the pregnancy? _____
<input type="checkbox"/> Y	<input type="checkbox"/> N	Did the mother have any depression during or after the pregnancy?
<input type="checkbox"/> Y	<input type="checkbox"/> N	Was the child full term?
<input type="checkbox"/> Y	<input type="checkbox"/> N	Did the child cry and have good color after delivery?
<input type="checkbox"/> Y	<input type="checkbox"/> N	Has the child developed normally?

ROS:

Has the child had any problems with the following?

- | | | | | | |
|---|---|-----------------|---|---|--------------------------|
| Y | N | Bed wetting | Y | N | destructiveness |
| Y | N | stool soiling | Y | N | cruelty to animals |
| Y | N | temper outburst | Y | N | self injury |
| Y | N | mood changes | Y | N | sleep problems |
| Y | N | anxiety | Y | N | getting along with peers |
| Y | N | depression | Y | N | stealing |
| Y | N | lying | Y | N | fire setting |

Family History:

Is there anyone in the family with the following problems? (M=mother F=father S=sibling, etc)

ADHD _____ depression _____ OCD _____
 Alcoholism _____ school problems _____ Bipolar _____

Any close family member with prolonged QT syndrome, congenital heart defect or sudden cardiac death Before the age of 40? _____

Tourette's syndrome _____ drug addiction _____

Social History:

With whom does the child live? _____

Has there been a major stress in your child's life?

- Y N Divorce? When? _____
 Y N Serious illness or death of a loved one? Who? _____ When? _____
 Y N Traumatic events? What and when? _____
 Y N Experienced sexual or physical abuse? _____

Y N Are there any future foreseeable stressors? _____

Other areas not addressed:

- Daniel P. Kraft, MD
- Timothy C. Bell, MD
- Shannon J. Fox-Levine, MD

- Cheryl E. Wayne, MD
- Nicole Pearson, MD
- Stacey Stout, MD

Palm Beach Pediatrics, PA

- J. Christie Goodwin, MD
- Dionne Skervin, MD
- Virginia Lilienthal, M.D.
- M.Jayne Brennan, ARNP
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