

UWMC ADULT AUTISM CLINIC – NEW PATIENT HISTORY AND INFORMATION

PLEASE NOTE: We encourage you to review these areas with other family members, such as parents, siblings or other individuals familiar with your early history.

Patient's Name: _____ M / F Age: _____ Birthdate: _____

Address _____ City _____ State _____ Phone _____
Person completing this form: _____ Relationship to patient: _____

Who is legally responsible for the patient: _____

Address _____ City _____ State _____ Phone _____
Referred to this clinic by: _____

Name _____ Address _____ City _____ State _____ Phone _____
Why are you seeking this evaluation? _____

PATIENT'S CURRENT LIVING SITUATION

Marital Status: _____

With whom does the patient currently reside? (check all that apply) Lives Independently

Spouse Life Partner Sibling

Biological Mother Biological Father Step-mother Step-father

Adoptive Mother Adoptive Father Group Home

Other (describe): _____

FAMILY CHANGES AND STRESSORS

What major family stresses is the family and/or patient currently experiencing or has experienced within the last year? (check all that apply)

Marital discord/fighting Separation/divorce Birth/adoption of a child

Parent-patient conflict Parent/sibling death Patient-child conflict

Family deployed extensively Family emotionally/mentally ill Involved in court

Family substance abuse Physical abuse Sexual abuse Financial problems

Loss of job Residential move Involved with Social Services/Protective Services

Other: _____

MEDICAL/SURGICAL HISTORY

Birth History

Any problems during pregnancy? None or explain: _____

Any problems immediately following birth? None or explain: _____

List any serious illnesses or other health problems (other than colds): None

Type _____ How Often _____ Approximate Date _____

PT.NO _____
NAME _____
DOB _____
Place EPIC Label Within Box

UW Medicine

Harborview Medical Center – UW Medical Center
Northwest Hospital & Medical Center – University of Washington Physicians
Seattle, Washington

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WHITE - MEDICAL RECORD

UH3220 REV JAN 13

MEDICAL/SURGICAL HISTORY (continued)

Current medications - please list below:

Type of Medication	Dose and Frequency	Reason

Past Medications list date and reason discontinued:

Hospitalizations/Surgeries: No Yes (if yes, list below)

Date	Hospital name and location	Reason

Serious Accidents or Injuries: No Yes (if yes, list below)

Date	Type

Drug or medication allergies? _____

Food allergies? _____

Environmental allergies? _____

Immunizations up to date? _____

DOCTORS SEEN NOW OR IN THE PAST

General Physician - name: _____ Date last seen: _____

Developmental Pediatrician - name: _____ Date last seen: _____

Neurologist - name: _____ Date last seen: _____

Geneticist - name: _____ Date last seen: _____

Psychiatrist - name: _____ Date last seen: _____

Gastroenterologist - name: _____ Date last seen: _____

Endocrinologist - name: _____ Date last seen: _____

DIAGNOSTIC TESTING

EEG (brain wave test) – Date: _____ Results: _____

MRI – Date: _____ Results: _____

CT scan – Date: _____ Results: _____

Ophthalmology evaluation – Date: _____ Results: _____

Chromosomal/DNA testing (Genetic) – Date: _____ Results: _____

Other (describe): _____

PT.NO _____

NAME _____

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WHITE - MEDICAL RECORD

FAMILY INFORMATION:

Birth Mother's Name: _____ Age: _____

Education (highest grade): _____

Place of Employment: _____ Telephone: _____

Medical/academic/learning problems: _____

Birth Father's Name: _____ Age: _____

Education (highest grade): _____

Place of Employment: _____ Telephone: _____

Medical/academic/learning problems: _____

Brothers/Sisters: List age and any medical/academic/learning problems: _____

FAMILY HISTORY

Have any members of the biological mother's or biological father's families had any of the following problems or disorders (check all that apply and relationship to patient):

- Birth Defect Chromosomal/genetic disorder Obsessive Compulsive Disorder
- Cerebral Palsy Severe head injury High blood pressure
- Kidney disease Migraine headaches Multiple Sclerosis
- Physical handicap Nervousness/Anxiety Stroke
- Tuberos Sclerosis Alzheimer's disease Hemophilia
- Huntington's chorea Muscular dystrophy Parkinson's disease
- Sickle-cell anemia Cancer Seizures/epilepsy
- Diabetes Heart disease Food allergies
- Alcohol/drug abuse Depression Physical/Sexual abuse
- Schizophrenia Mental Retardation Speech/language delay
- Autism/PDD Reading problem Other learning disability
- Emotional disturbance/mental illness Bipolar/manic-depressive disorder
- Tics/Tourette's syndrome Antisocial Behavior (assaults, thefts, arrests, etc.)
- Childhood behavior disorder (aggressive/defiant/ADHD) Other: _____

Has anyone in the family ever received special education services? No Yes, for what reason? _____

SCHOOL HISTORY

Patient's Highest Level of Education: 11th grade or less High school graduate GED

Vocational Certificate Associates Degree

Bachelor's Degree

Graduate/Professional

Did the patient have an IEP (Individualized education plan)? For what reason? _____

Psychological/cognitive testing-Date: _____ Academic testing-Date: _____

PT.NO _____

NAME _____

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WHITE - MEDICAL RECORD

WORK HISTORY

Current Employer: _____ Occupation: _____

Employed since: _____ # of hours: _____

Require vocational assistance? Yes No

Currently working with Department of Vocational Rehabilitation (DVR): Yes No

Past employer and date employed: _____

PAST/CURRENT SERVICES

Physical Therapy provide by: _____ Dates seen: _____

Occupational Therapy provided by: _____ Dates seen: _____

Speech Therapy provided by: _____ Dates seen: _____

Vocational Therapy provided by: _____ Dates seen: _____

Social Skills provided by: _____ Dates seen: _____

Psychotherapy provided by: _____ Dates seen: _____

Other: (describe) _____ Dates seen: _____

REVIEW OF SYSTEMS: Circle or check any past or current problems (if yes, please explain)

Eyes/vision problems No Yes _____

Ear, nose, or throat problems (recurrent ear infections) No Yes _____

Gastrointestinal problems (stomach, digestive, constipation) No Yes _____

Growth/weight problems No Yes _____

Kidney problems No Yes _____

Heart or blood pressure problems No Yes _____

Blood Abnormalities (anemia, leukemia, etc.) No Yes _____

Respiratory problems (asthma, sleep issues, snoring) No Yes _____

Neurological problems (seizures, shunts, bleed, stroke, meningitis) No Yes _____

Skin problems (rashes, acne, eczema, etc.) No Yes _____

Endocrine problems (thyroid, diabetes) No Yes _____

Musculoskeletal (joints or bone) problems No Yes _____

Psychiatric problems (depression, bipolar, etc.) No Yes _____


Smoker: No Yes, if yes how many packs per day ____ Year last quit _____

Alcohol: No Yes, if yes number of drinks per week _____

Other drug use (describe): _____

What questions would you like answered at your appointment?

PT.NO _____
NAME _____
DOB _____
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