Patient Name: Date of Birth: Account Number:

PATIENT INFORMATION - PEDIATRIC NEUROLOGY CONSULTATION

*This detailed **(confidential)** information will help your doctor identify areas of concern for your child. Some sections may not apply to your child, but please complete as many sections as possible. This information will be considered a confidential part of the medical record.*

Age: Handedness: __ Right __ Left __ Not established yet Gender: ___Male ___Female

School Grade: _____ School Name: _____

Pediatrician or family doctor: _____

Birth and pregnancy history:

Birth weight: _____ Born at _____ weeks of pregnancy ___vaginal ___c-section
Apgar scores (if known): _____ ___Planned ___Surprise
Were fertility treatments used? ___No ___Yes ___ IVF
Mother's pregnancy history: Number births _____ Number miscarriages _____
Medications during pregnancy: ___None
___Prenatal vitamins, started at _____ weeks
___Other _____ _____
Please check all that apply to your child's pregnancy:
___Fever or infection in the mother ___High blood pressure ___Pre-eclampsia
___Diabetes ___Vaginal bleeding ___Smoking
___Alcohol use ___Vomiting requiring medical treatment
___Other complication: _____
Nursery stay:___3 days or less___more than 3 days – How long? _____

Developmental history:

Rolled over at _____
Sat at _____
Crawled at _____
Walked independently at _____ ___Not yet
First word with meaning, without prompting at _____ ___Not yet
Combined 2 words at _____ ___Not yet
Toilet trained at _____ ___Not yet
Has your child ever had loss of speech or developmental skills? ___no ___yes
Does your child receive: Physical therapy? ___no ___yes How often? _____
Occupational therapy? ___no ___yes How often? _____
Speech therapy? ___no ___yes How often? _____

Current Medications:

Please list any medications your child takes, including vitamins or supplements.
Name: _____ Dose: _____
_____ _____
_____ _____
_____ _____

Does your child have a medication allergy? ___ yes ___ no
Please list any medication allergies: _____

Please list any alternative, chiropractic, or supplemental therapies: _____

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Medication history:

What medications has your child tried previously for the condition that brings you to the neurologist today?

Medication:	Maximum dosage:	When, and for how long?
Example: Depakote	*500 mg twice daily*	*November 2007 to May 2008*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past medical history:

___ Ear infections __ None __ Rarely __ Many
___ Asthma
___ Headaches
___ Seizures __ With Fever __ Without Fever
___ Breath-Holding Spells
___ Passing out (syncope) When?_____
___ Meningitis
___ Encephalitis
___ Head Injuries
___ Measles
___ Chicken Pox
___ Dehydration (Diarrhea)
___ Allergies
___ ADHD or ADD
___ Learning disabilities
___ Behavioral disabilities

Immunizations:

__ Up to Date
Adverse reaction to immunization?
__ Yes __ No
If yes, please describe Reaction:
_____
_____
_____

Previous Hospitalizations;

_____
_____

Previous Surgeries (include dates) __ None __ Ear Tubes _____ __ Tonsils

_____
_____

Other: _____

Academic Performance:

Typical grades: ___As ___Bs ___Cs ___Ds ___Failing
Best subjects: _____
Areas of difficulty: _____
Recent worsening of school performance: ___no ___yes
Special education services, IEP, EBD, or chapter/title services? ___no ___yes
Sports/activities: _____
_____

Psychosocial:

Parents are: ___ Married ___ Never Married ___ Live together ___ Divorced ___ Separated
If divorced
Both parents involved: __ Yes __ No __ Share Custody __ Maternal Custody __ Paternal Custody
Does child attend daycare? ___no ___yes, licensed __ yes, unlicensed
Does child smoke? ___never smoked ___previous smoker, if quit when____
____current smoker, how much?____ how often? ____ ___ unknown if ever smoked
Any smokers in the household? ___no ___yes, indoors __ yes, outdoors only
Is anyone abusing your child physically, emotionally, or sexually? ___no ___yes
Has your child been abused in the past? ___no ___yes
Does your child have problems making and maintaining eye contact? ___no ___yes
Does your child have problems in school? ___no ___yes
Does your child interact well with other children? ___no ___yes

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Family history:

Some genetic and acquired conditions are associated with ethnic origin and occupational factors. Please specify for example whether they were English, Danish, French, Swiss, Eastern European, Mexican, etc.

Parents	Age	Health condition	Occupation	Ethnicity	Lives at Home
Biologic father					___no ___yes
Biologic mother					___no ___yes
Brother (s)					___no ___yes
					___no ___yes
					___no ___yes
Sister(s)					___no ___yes
					___no ___yes
					___no ___yes

Has any relative (biologic relative to the patient) had any of the following difficulties?

Seizures	___no	___yes	Who? _____
Headaches	___no	___yes	Who? _____
Muscle disease	___no	___yes	Who? _____
Intellectual disability	___no	___yes	Who? _____
Autism	___no	___yes	Who? _____
ADD/ADHD	___no	___yes	Who? _____
Learning disability	___no	___yes	Who? _____
Tics	___no	___yes	Who? _____
Depression, anxiety	___no	___yes	Who? _____
Bipolar, manic/depressive	___no	___yes	Who? _____
Schizophrenia	___no	___yes	Who? _____
Brain tumor	___no	___yes	Who? _____
Multiple sclerosis	___no	___yes	Who? _____
Aneurysm	___no	___yes	Who? _____
Stroke under age 50	___no	___yes	Who? _____
Heart attack under age 50	___no	___yes	Who? _____
Multiple miscarriages	___no	___yes	Who? _____
Blood clotting disorder	___no	___yes	Who? _____
Death of baby or small child	___no	___yes	Who? _____
Other	_____		

System Review:

Please mark any of the following that apply to your child:

___Headaches	___Seizures	___Dizziness
___Vision changes	___Hearing difficulty	___Fainting
___Trouble walking	___Muscle weakness	___Neck or back pain
___Urination	___Constipation	___Diarrhea
___Seems depressed	___Seems anxious	___Abnormal movements
___Heart palpitations	___Excessive thirst	___Feeling excessively cold
___Rash	___Excessive fatigue	___Excessive sleepiness
___Snoring	___Easy bruising	___Difficulty sleeping
___Abdominal pain	___Skin or hair changes	___Unexpected weight gain or loss
___Not able to sweat	___Appetite changes	___Inability to play in hot weather

Other: _____

When was vision last checked? _____ ___never

When was hearing last checked?_____ ___never