MRN#

Pediatric Neurology
Patient History

STAFF: Responses in boxes and handwritten items must be entered **MANUALLY**.

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

Primary Care Physician: _____ **Referring Physician:** _____

REASON FOR VISIT

Please list current or previous neurologic symptoms:

_____

_____

BIRTH HISTORY

During pregnancy with patient, list any medications used by mom:

_____

Please check any of the following that apply to the patient's birth:

vaginal delivery with vacuum ◯ induced vaginal delivery ◯ vaginal delivery with forceps ◯

Age of child when discharged from hospital: _____

REVIEW OF SYSTEMS

Please check all symptoms that have been present recently:

GENERAL	weight loss ◯	weight gain ◯	sleep problems ◯	NONE ◯
EYES / THROAT		double vision ◯	difficulty swallowing ◯	NONE ◯
CHEST			heart palpitations ◯	NONE ◯
RESPIRATORY		wheezing ◯	allergies ◯	NONE ◯
GASTROINTESTINAL		nausea / vomiting ◯	reflux ◯	NONE ◯
MUSCULOSKELETAL		curved spine / scoliosis ◯	flat feet ◯	NONE ◯
SKIN		loss or thinning of hair ◯	birthmark(s) ◯	NONE ◯
GENITOURINARY			kidney stones ◯	NONE ◯
PSYCHIATRIC			depression / seems sad ◯	
		suicidal thoughts / attempts ◯	rituals or obsessions ◯	NONE ◯
BEHAVIOR		trouble following directions ◯	talks excessively ◯	
		easily distracted ◯	interrupts others ◯	
	acts without thinking ◯	hyperactive ◯	disorganized ◯	NONE ◯
NEURO		headaches ◯	seizures ◯	NONE ◯

FAMILY MEDICAL HISTORY

◯ **Family History UNKNOWN** ◯ **ADOPTED**

Please indicate which of the patient's family member(s) have had these illnesses:	Father	Mother	Grandmother *Mother's side*	Grandfather *Mother's side*	Grandmother *Father's side*	Grandfather *Father's side*	Brother	Sister
Muscular Dystrophy	◯	◯	◯	◯	◯	◯	◯	◯
Other Neurological Disease	◯	◯	◯	◯	◯	◯	◯	◯
Tics	◯	◯	◯	◯	◯	◯	◯	◯

NONE ◯

SOCIAL HISTORY

Mother's name: _____ Home: _____ Cell: _____ Occupation: _____

Father's name: _____ Home: _____ Cell: _____ Occupation: _____

Handedness of the patient: Right ◯ Left ◯ Uses Both ◯

Is the child working at or above his / her grade level in school? N/A ◯ Yes ◯ No ◯

What are his / her interests or activities? _____

Results of previous studies (EEG, CT Scan or MRI): _____

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SAMPLE

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