

Pediatric Neurology Hackensack UMC Patient and Family History

Patient Name: _____
Date of Birth: ___/___/___ Age: ___ years

Form filled out by: _____ Relationship to child: _____

In a few words, why are you here to see the doctor?

Referred to Pediatric Neurology by:

Has your child ever seen another Neurologist or other Specialist for an evaluation related to this problem? What tests were done? Results? Treatment? Outcome?

Who is your child's primary care physician?
Name: _____
Address: _____
Phone: _____

Other Physicians involved in your child's care:
Doctor's Name: _____
Specialty: _____
Address: _____
Phone #: _____

Doctor's Name: _____
Specialty: _____
Address: _____
Phone #: _____

Doctor's name: _____
Specialty: _____
Address: _____
Phone #: _____

BIRTH HISTORY:
Full Term: Yes No (If no, how early: _____ weeks)
Type of delivery: Vaginal C-section Forceps Vacuum
Adopted? Yes No
Were there any problems with: Pregnancy Birth
Please explain: _____

PAST MEDICAL HISTORY:
Has your child ever had any major illness in the past? No Yes
Please explain:

Has your child ever been hospitalized? No Yes

If yes, please explain when, why, where, the treatment provided, and by whom:

Has your child ever had surgery? No Yes

If yes, explain type of surgery, when, where, and by whom:

Are your child's Immunizations Up-to-Date? No Yes

MEDICATIONS: (including over-the-counter medicines, herbs, vitamins etc)

Currently taking:

Past medications:

Allergies to medications/reactions:

Other allergies:

GROWTH AND DEVELOPMENT:

Right-handed Left handed

Age at which child: _____ Rolled over: _____ Sitting: _____ Walking _____ Talking _____

Has the child lost any milestones? If yes, please explain: _____

Grade in school: _____ School performance: _____

Special Education needs: No Yes

Please explain:

- Physical Therapy Occupational Therapy Speech Therapy
- Extra help/resource room 504 Plan IEP

FAMILY HISTORY:

Mother's Age: _____ Medical issues: _____

Father's Age: _____ Medical issues: _____

Siblings/ages/Medical Issues:

Does anyone in the immediate family have one of the following conditions?:

- Mental retardation Headaches/Migraines
- Learning issues Seizures
- Developmental delay Cerebral palsy
- ADD/ADHD Deafness
- Tics Blindness

- Cancer
- Psychiatric disorder (anxiety, depression, bipolar etc)

SOCIAL HISTORY:

Who lives with the patient? _____

How easily does your child make friends? _____

Does your child work? No Yes

REVIEW OF SYSTEMS:

Is your child having any of these issues currently or in the recent past?

- Weight/appetite changes
- Stomach pain/nausea/vomiting
- Difficulty eating/swallowing
- Blurry vision/double vision
- Feeding issues/problem
- Dizziness
- Seizures
- Numbness/weakness
- Headaches
- Speech problems
- Behavioral Problems
- Hearing problems
- Difficulty concentrating
- Sleep problems
- Breathing problems
- Walking problems
- Fast heartbeat, chest pain
- Rash/birthmarks
- Fatigue/tiredness

For females, menses No Yes Age at onset: _____ Problems? No Yes

If you answered YES to any of the above, please explain:

Is there anything else you would like us to know about your child, the reason for this visit, and your expectations?

OFFICIAL USE ONLY:

Reviewed by: _____

Date: _____