

Associated Neurological Specialties

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Pediatric Medical History

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Your Name: _____

Relationship to Patient: _____

Child's Primary Care Doctor and phone number:

Other doctors who should receive a copy of our report with phone numbers:

Child's Problem:

Current Medications:

Medication

Dosage

How Often

List Any Allergies or Other Problems Caused By Medications

Has your child had any of the following tests?

<u>Test</u>	<u>Date</u>	<u>Where</u>	<u>Results</u>	
MRI	_____	_____	Normal	Abnormal
CT	_____	_____	Normal	Abnormal
EEG	_____	_____	Normal	Abnormal

Other Tests:

Past Medical History

Birth History:

Was your child born early or after nine months of pregnancy? **Early**____ **Full Term**_____

If early, how many weeks gestation? _____ Birth Weight _____

Was a C-section performed? **Yes**_____ **No**_____

Were there complications during the pregnancy or at delivery? **Yes**_____ **No**_____

If so, what was the complication? _____

Did the baby come home with you from the hospital? **Yes**_____ **No**_____

If not, how long did the baby stay in the hospital?

Has your child ever been hospitalized or had any surgeries?

Age _____ Reason _____

Age _____ Reason _____

Age _____ Reason _____

Has your child had all of his/her immunizations required for his age?

Yes_____ **No**_____ **Not Sure**_____

Has your child ever had any of the following? If so, when?

Seizure: With Fever _____ Without Fever _____

Head Injury _____ Loss of Consciousness _____

Severe Headache _____ Hearing Problems _____

Vision Problems _____ Frequent Day-dreaming _____

Problems Sleeping _____ Daytime Sleepiness _____

Unexplained Vomiting _____ Loss of Balance _____

Weakness of Extremities _____ Paralysis of Extremities _____

Numbness/ Tingling _____ Double Vision _____

Does your child have problems with any of the following?

Asthma _____ Other breathing Issues _____

Nose or Throat _____ Thyroid _____

Heart _____ Stomach Pain or Digestive _____

Changes in Bowel or Bladder Function _____

Weight Loss or Gain _____ Swollen Lymph Nodes _____

Rashes or Skin _____ Bruising or Bleeding _____

Motor coordination _____

Has your child ever been seen by a specialist (eye doctor, heart doctor, lung doctor, etc.)?

Yes No If yes, who? _____

Development

At what age did your child learn the following skills?

Rolling Over _____ Sitting _____ Crawling _____

Walking _____

First Words _____ Speaking in Sentences _____

Toilet Trained _____

Has your child ever received any physical therapy? _____

Has your child ever received any speech therapy? _____

If so, how often does he/she get therapy? _____

If so, where? _____

Grade level in school _____

Has he/she ever received educational support? Yes No

Has he/she received special education? Yes No

Are there any problems in school with the following:

Reading _____ Motivation _____

Attention _____ Behavior _____

Relationship with peers _____ Relationship with teachers _____

Family

Please list ages of all brothers and sisters:

Who in the family has had any of these problems? (Please include parents, brothers, sisters aunts, uncles, grandparents, and cousins.)

Seizures _____ Learning Disabilities _____

Migraines or Headaches _____ Genetic Diseases _____

Depression _____ Bipolar Disorder _____

Autism _____ Attention Problems _____

Brain Tumor _____ Substance Abuse _____

Mental Retardation _____ Movement Disorder/ Tics _____

Are there any other medical problems that run in the family?

Social

Who lives at home with your child?

Are the parents: Married Divorced Never Married Separated

Parent's occupation:

Father: _____ Mother: _____

Is there any additional information you would like the doctor to know?

Are there specific questions you would like to address at this visit?
