

*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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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?

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

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