



0300004

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DEPARTMENT OF NEUROLOGICAL SURGERY MEDICAL HISTORY FORM – PEDIATRIC PATIENTS

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR SCHEDULED APPOINTMENT AS WELL AS ALL YOUR MEDICATIONS AND ANY PRIOR MEDICAL RECORDS OR X-RAYS

Please assist in obtaining the most accurate information regarding your medical history by completing the information below. If you have already completed this form for our department, please disregard. Your assistance is greatly appreciated.

GENERAL INFORMATION:

Date: _____

Name _____
LAST FIRST MIDDLE INITIAL

Home Address _____
(CITY) (STATE) (ZIP CODE)

Home Phone () _____ Work Phone () _____

Date of Birth: _____ Gender (check one): Male Female Are you: Left-handed Right-handed Ambidextrous

1. Please give the name, address, and phone # of your pediatrician / family Dr. and any referring Dr.'s you would like information sent to: _____

2. What is the main reason for your visit today? _____

3. Did you bring medical records, slides, and/or x-rays with you today? Yes No

HISTORY OF PRESENT ILLNESS: Please describe the symptoms of your medical problem.

Location and Severity of Problem: _____

How long have you had the symptoms? _____ When do you have the symptoms? _____

What makes the symptoms better or worse? _____

MEDICAL HISTORY:

1. Term Birth? Yes _____ No _____ If not, birth at _____ weeks gestation. Method of delivery: Vaginal _____ C-Section _____

2. List any medical conditions you have:

MEDICAL CONDITIONS

Condition	When Diagnosed?	Condition Currently Under Treatment

3. Have you ever been hospitalized or had surgery? No Yes If yes, please list all previous surgeries and hospitalizations below (include dates and hospitals when possible).

HOSPITALIZATIONS

Date of Hospitalization	Type of Surgery	Reason for Surgery

4. DEVELOPMENTAL HISTORY: (circle all that apply)

- | | | | |
|---------------------------------|---------------------------|-------------------------------|----------------------------|
| Able to hold head up | Able to sit up unassisted | Able to imitate speech/sounds | Able to speak in sentences |
| Able to follow object with eyes | Able to crawl | Able to walk | Able to use fork and spoon |
| Able to grasp toy | Able to feed self | Able to speak simple words | Able to dress self |
| | | | Able to broad jump |

5. ARE YOU CURRENTLY UNDERGOING:

Physical Therapy No Yes Occupational Therapy No Yes Speech Therapy No Yes

6. Do you take any medications? No Yes If yes, please list below:

CURRENT MEDICATIONS

Name/Dose/Route of Medication	Date Started Medication	How Often Is It Taken?	Reason for Taking Medication

7. Do you have any known drug allergies? No Yes If yes, please list them below:

KNOWN ALLERGIES

Name of Medication	Reaction to Medication

FAMILY HISTORY: (Please list any illnesses that run in your family, including heart disease, diabetes, seizures, or cancer)

SOCIAL HISTORY: (Please circle the correct answer)

• Education: PRESCHOOL GRADE SCHOOL MIDDLE SCHOOL HIGH SCHOOL COLLEGE

Who do you live with? _____

REVIEW OF SYSTEMS: (Please check all that describe your symptoms)

<p>Constitutional</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Weight loss</p> <p>Cardiovascular</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Irregular heart beat</p> <p>Respiratory</p> <p><input type="checkbox"/> Chronic cough / Coughing blood</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Asthma</p> <p>Gastro-Intestinal</p> <p><input type="checkbox"/> Blood in stool/Dark colored stool</p>	<p><input type="checkbox"/> Nausea/Vomiting</p> <p><input type="checkbox"/> Abdominal Pain</p> <p><input type="checkbox"/> Incontinence / Constipation / Diarrhea</p> <p>Genito-Urinary</p> <p><input type="checkbox"/> Burning with Urination</p> <p><input type="checkbox"/> Difficulty starting / ending urine stream</p> <p><input type="checkbox"/> Poor bladder control of incontinence</p> <p><input type="checkbox"/> Loss of sensation of genitals</p> <p><input type="checkbox"/> Inability to obtain, maintain erection</p> <p>Endocrine</p> <p><input type="checkbox"/> Nipple discharge</p>	<p><input type="checkbox"/> Dry skin</p> <p><input type="checkbox"/> Loss or gain of body hair</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Weight loss or gain</p> <p><input type="checkbox"/> Excessive thirst</p> <p>Hematologic</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> History of excessive bleeding with previous surgeries</p> <p>Neurological</p> <p><input type="checkbox"/> Change in vision (blurry, double)</p> <p><input type="checkbox"/> Loss of hearing or ringing in ears</p> <p><input type="checkbox"/> Facial numbness</p>	<p><input type="checkbox"/> Facial weakness</p> <p><input type="checkbox"/> Decreased sense of smell or taste</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Slurred speech</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Seizures</p> <p>Musculoskeletal</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Arm pain / numbness / weakness</p> <p><input type="checkbox"/> Loss of arm / hand coordination</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Leg pain / numbness</p>
---	--	---	---

Completed by: _____
Patient / Parent / Guardian Signature

Reviewed by: _____ PIC # _____ Title _____ Date _____