PEDIATRIC NEUROLOGY HISTORY

DATE: ______________________________

CHILD'S FULL NAME: ______________________________

This information, in your own words, will help the physician to understand and treat your child. It will be kept **CONFIDENTIAL**. A report of this and any future visits will only be sent to a doctor and/or school in which you designate.

NAME OF REFERRING DOCTOR: ______________________________

ADDRESS/PHONE: ______________________________

NAME OF SCHOOL: ______________________________

ADDRESS/PHONE: ______________________________

I hereby give permission to send a copy of this report to the above named doctor and/or school

(Circle either or both). ______________________________

(Signature of Parent or Legal Guardian)

CHILD'S NAME:
(As used at home) ______________________ AGE: ____ years ____ months

REASON FOR COMING (symptoms or complaints): ______________________________

____

____

AT WHAT AGE DID THIS BEGIN? ______________________________

HOW HAS THIS DEVELOPED? OVER WHAT PERIOD OF TIME? (slowly, quickly, always appears the same, etc.): ______________________________

____

WHAT TESTS HAVE BEEN DONE AND WHERE? ______________________________

____

____

WHAT TREATMENTS AND/OR MEDICATIONS HAVE BEEN USED? ______________

____

____

PHYSICIAN SIGNATURE: ______________________________

NAME: ______________________________ DOB: ______________

PEDIATRIC NEUROLOGY HISTORY (cont'd)

FAMILY HISTORY: Present Age Of

MOTHER ________

FATHER ________

SISTERS ________

BROTHERS ________

PARENTS: _____ MARRIED _____ SEPARATED _____ DIVORCED

WHO LIVES AT HOME WITH THIS CHILD? ______________________________

____

HAVE THERE BEEN SIMILAR SYMPTOMS IN OTHER MEMBERS OF THE FAMILY?

MOTHER'S SIDE: ____

____

FATHER'S SIDE: ____

____

CHILD'S EARLY HISTORY:

PREGNANCY (complications): ______________________________

DURATION (full term, premature, etc.): ______________________________

LABOR AND DELIVERY (complications): ______________________________

____

BIRTH WEIGHT: ______ pounds ______ ounces

GROWTH AND DEVELOPMENT:

Rolled over ______ months

Sat ______ months

Walked ______ months

First Words ______ months

Speech Development ______ months

Handedness: Right Left Both

Age preference appeared: __________

Rode a Tricycle ______ years

Rode a Bicycle ______ years

PHYSICIAN SIGNATURE: ______________________________

NAME: ____________________ DOB: __________

PEDIATRIC NEUROLOGY HISTORY (cont'd)

GROWTH AND DEVELOPMENT (cont'd):

ILLNESSES: ____________________

HOSPITALIZATIONS: ____________________

CURRENT MEDICATIONS: ____________________

MEDICATION ALLERGIES: ____________________

CHILD'S SOCIAL HISTORY (note any special strengths and/or weaknesses):

Daycare/Preschool ____________________

Kindergarten ____________________

Grades 1,2,3 ____________________

Grades 4,5,6 ____________________

Grades 7,8,9 ____________________

Grades 10,11,12 ____________________

PHYSICIAN SIGNATURE ____________________