Banner Health®

NEW PATIENT MEDICAL HISTORY
PEDIATRIC NEUROLOGY

PATIENT NAME: _____ *DOB*: _____/_____/_____

PATENT/GUARDIAN NAME: _____

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse.

Referred for Evaluation by: _____

Preferred Pharmacy: (name and location) _____

CHRONIC MEDICAL PROBLEMS: ❑ None, healthy

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATION ❑ No Medications

1. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
2. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
3. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
4. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
5. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
6. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____
7. _____ Dosage: _____ # of Times a Day: _____
   Reason for medication: _____

ALLERGIES ❑ No Allergies

Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____
Allergy: _____ Reaction: _____

REASON FOR VISIT:

1. _____
2. _____
3. _____

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Is the patient experiencing any of the following? Please mark Yes or No to each symptom.

CONSTITUTIONAL			GASTROINTESTINAL			NEUROLOGICAL		
No	Yes		No	Yes		No	Yes	
		Chills			Abdominal pain			Appropriate interaction
		Decreased Activity			Constipation			Behavioral changes
		Decreased Appetite			Diarrhea			Consolable
		Fever			Nausea			Difficulty concentrating
		Fussiness			Reflux			Distorted body image
		Irritability			Vomiting			Self conscious
		Lethargy						Aphasia
		Weight gain						Dizziness
		Weight loss						Speech disorder
HEENT			GENITOURINARY					Focal weakness
No	Yes		No	Yes				Gait disturbance
		Difficulty swallowing			Decreased urine output			Headache
		Ear discharge			Painful urination			Incontinence
		Crossed eye			Unable to control urination			Incoordination
		Eye discharge			Flank pain			Light-headedness
		Eye redness			Foul urine odor			Loss of consciousness
		Headache			Blood in urine			Memory impairment
		Hearing loss	REPRODUCTIVE FEMALE					Near syncope
		Nasal congestion	No	Yes	Painful periods			Paresthesia
		Ear pain			Heavy period			Seizures
		Sore throat			Vaginal discharge			Speech changes
		Nasal drainage			Vaginal itching			Tremors
		Sneezing						Vertigo
		Tearing						Visual Changes

RESPIRATORY			REPRODUCTIVE MALE			PSYCHIATRIC		
No	Yes		No	Yes		No	Yes	
		Difficult breathing			Circumcised			Appropriate interaction
		Wheezing			Penile discharge			Consolability
		Use of accessory muscles			Scrotum, testicular mass			Difficulty concentrating
		Cough			Scrotum testicular pain			Psychiatric/emotional
		Known exposure to Tb	METABOLIC ENDOCRINE			MUSCULOSKELETAL		
		Sputum						
CARDIOVASCULAR			No	Yes		No	Yes	
No	Yes				Excessive thirst			Bone pain
		Chest pain			Polyuria (voiding a lot)			Joint pain
		Irregular heartbeat	VASCULAR					Joint swelling
		Syncope/fainting						Muscle weakness
Heart murmur			No	Yes				Muscle pain
		Structural defect			Cool extremity			
		Palpitations			Rash			
HEMATOLOGIC			IMMUNOLOGICAL					
No	Yes		No	Yes				
		Easy bleeding			Allergic rhinitis			
		Easy bruising			Environmental, allergies			
		Swollen glands			Food Allergies			

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(12/2015)

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PREGNANCY HISTORY: ❑ unknown ❑ adopted

What number pregnancy was this child? _____

Any miscarriages or abortions? _____

Any illnesses or complications with pregnancy? _____

What medications were taken during pregnancy (including prenatal vitamins)? _____

_____

Ultrasounds? ❑ Normal ❑ Not normal because _____

BIRTH HISTORY:

Gestational age: ❑ Full term (40 weeks) ❑ Early: _____ weeks

Birth weight: _____ lbs _____ oz

Length: _____ in

Head size: _____ in _____ ❑ unknown but physicians had no concerns

Any complications after birth: _____

Length of stay at the hospital: _____

❑ Breast Fed ❑ Bottle fed formula ❑ Both

Passed Hearing Screen? ❑ Yes ❑ No

MED/SURG/INTERIM History (Hospitalization, ER visits, and Surgeries)

Hospital stays:

1. Reason: _____ Dates: _____
2. Reason: _____ Dates: _____
3. Reason: _____ Dates: _____

ER visits:

1. Reason: _____ Dates: _____
2. Reason: _____ Dates: _____
3. Reason: _____ Dates: _____

Surgeries:

1. _____ Dates: _____
2. _____ Dates: _____
3. _____ Dates: _____

DIAGNOSTIC TESTS:

❑ CT head: _____/_____/_____ ❑ MRI brain: _____/_____/_____ ❑ MRA/MRV: _____/_____/_____

❑ EEG: _____/_____/_____ ❑ EMG: _____/_____/_____ ❑ Other: _____

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FAMILY HISTORY:

Mother: _____

Father: _____

Siblings: _____

_____

_____

Maternal Grandmother (mom's side): _____

Maternal Grandfather (mom's side): _____

Paternal Grandmother (dad's side): _____

Paternal Grandfather (dad's side): _____

OTHER: (aunts/uncles/cousins): In particular, any cerebral palsy, muscle weakness/dystrophies, strokes in young (<55years old), autism, developmental delays, birth defects, multiple sclerosis, sudden unexplained deaths, and other illnesses that you know of?

_____

_____

_____

_____

_____

SOCIAL HISTORY:

Who lives in the house? _____

Any pets? _____

Who smokes in the family (including patient in patient smokes)? _____

Mother's occupation: _____

Father's occupation: _____

Any special spiritual/religious needs? _____

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(12/2015)