

Pediatric Neurologists of Palm Beach

Medical History Form

NOTE: This information is for medically confidential use only and will not be released to unauthorized persons

| | |
|----------------|------------------------|
| Patient's Name | Primary Care Physician |
| Date of Birth | Date of Visit |

Gender

- female
 male

Race (optional)

- Alaskan Native/American Indian
 Asian
 Black/African American
 Native Hawaiian/Pacific Islander
 White

Primary Language(s)

- Creole
 English
 Spanish
 other _____

Is the patient (check any that apply)

- adopted
 in a foster home
 residing somewhere
 other than with parents
 (explain) _____

Ethnicity (optional)

- Hispanic/Latino
 Not Hispanic/Latino

Handedness

- left
 right
 none/ambidextrous

| MEDICAL HISTORY | |
|--|---|
| Please list all current and past medical problems/injuries | Please list all prior surgeries, hospitalizations and dates |
| | |
| | |
| | |
| | |
| | |

| MEDICATIONS | Doses and times | ALLERGIES |
|--------------------|-----------------|------------------|
| | | |
| | | |
| | | |
| | | |
| | | |

| REVIEW OF SYSTEMS | | | | | | | | |
|----------------------------------|-----|----|------------------------------|-----|----|---------------------------------|-----|----|
| DOES THE PATIENT EXPERIENCE: | yes | no | DOES THE PATIENT EXPERIENCE: | yes | no | DOES THE PATIENT EXPERIENCE: | yes | no |
| fevers or night sweats | | | shortness of breath | | | bone/joint pain or swelling | | |
| recent significant weight change | | | stops breathing (apnea) | | | rashes or skin lesions | | |
| excessive fatigue | | | recurrent abdominal pain | | | easy bruising or bleeding | | |
| hearing abnormalities or loss | | | nausea/vomiting | | | excess drinking/urinating | | |
| visual problems | | | recurrent diarrhea | | | feeling excessively hot or cold | | |
| heart pounding or racing | | | blood in stools | | | frequent headaches | | |
| chest pain | | | severe constipation | | | recurrent dizziness or fainting | | |
| exercise intolerance | | | painful/difficult urination | | | depression/suicidality | | |
| persistent cough | | | blood in urine | | | hallucinations | | |

| BIRTH HISTORY | | | | | | | | | | |
|---|-----|----|--|-----|----|-----------------|--|--|--|--|
| Birth weight | lbs | oz | Was the pregnancy full term? | yes | no | How many weeks? | | | | |
| Delivery was (check all that apply): <input type="checkbox"/> routine, <input type="checkbox"/> emergent, <input type="checkbox"/> vaginal, <input type="checkbox"/> forceps, <input type="checkbox"/> vacuum, <input type="checkbox"/> c-section | | | | | | | | | | |
| Medications/drugs/alcohol taken during pregnancy: | | | | | | | | | | |
| PREGNANCY | yes | no | How long did he/she stay in the hospital after birth? | | | | | | | |
| vaginal/placental bleeding | | | Please list any other complications of the pregnancy, labor or delivery: | | | | | | | |
| maternal diabetes | | | | | | | | | | |
| if yes, required insulin? | | | | | | | | | | |
| pre-eclampsia | | | | | | | | | | |
| maternal seizures | | | | | | | | | | |

| DEVELOPMENTAL HISTORY | | | | | | | | | | | |
|---|-----|----|-----|----------------------|-----|----|-----|-----------------|-----|----|-----|
| Did the patient achieve the following milestones at the normal age? | | | | | | | | | | | |
| MILESTONE | yes | no | age | MILESTONE | yes | no | age | MILESTONE | yes | no | age |
| roll over | | | | walk with hands held | | | | combine words | | | |
| sit up unassisted | | | | walk unassisted | | | | short sentences | | | |
| pull to stand | | | | first words | | | | potty trained | | | |

| FAMILY HISTORY | | | | | | | | | | |
|--|-----|------------------|------------------|-----------------------------|------------------|----|-----|--|--|--|
| name | age | occupation | medical problems | | | | | | | |
| mother | | | | | | | | | | |
| father | | | | | | | | | | |
| brothers/sisters | age | medical problems | brothers/sisters | age | medical problems | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| | | | | | | | | | | |
| Do any family members have | yes | no | who | Do any family members have | yes | no | who | | | |
| seizures/epilepsy | | | | tics/Tourette syndrome | | | | | | |
| headaches/migraines | | | | depression/bipolar disorder | | | | | | |
| physical handicaps/cerebral palsy | | | | schizophrenia | | | | | | |
| mental handicaps/learning disability | | | | autism | | | | | | |
| other neurological, medical or genetic disorders (specify) | | | | | | | | | | |

| SLEEP HISTORY | | | | | | | | | |
|---|-----|--|---|----------------------------|----|---|-----|----|--|
| Usual bed time (school days) | | How long does it usually take to fall asleep | | Usual morning wake up time | | Does he/she wake feeling refreshed? | yes | no | |
| DOES THE PATIENT | yes | no | DOES THE PATIENT | yes | no | DOES THE PATIENT | yes | no | |
| snore significantly | | | wake frequently at night | | | toss or kick frequently in sleep | | | |
| have difficulty with or stop breathing (apnea) in sleep | | | have pains, unusual sensations or restlessness of their legs at night | | | have excessive sleepiness or fall asleep easily when not busy | | | |

| BEHAVIOR AND SCHOOL PERFORMANCE | | | | | | | | | | | |
|---------------------------------|-------|-----------------------------------|--------------------------|-----|------------|--|-----|----|---|---|---|
| name of school | grade | has he/she ever repeated a grade? | yes | no | what grade | Average grades (circle all that apply) | A | B | C | D | F |
| DOES THE PATIENT | yes | no | DOES THE PATIENT | yes | no | DOES THE PATIENT | yes | no | | | |
| receive tutoring | | | receive physical therapy | | | have problematic behavior | | | | | |
| have ESE/special classes | | | occupational therapy | | | drastic mood swings | | | | | |
| have an IEP or 504 plan | | | speech therapy | | | tics/involuntary movements | | | | | |

Please describe briefly the reason for your visit:

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge.

| | | | |
|---------------------------------|-------------------------|-----------|------|
| Name of person filling out form | Relationship to patient | Signature | Date |
|---------------------------------|-------------------------|-----------|------|