UF UNIVERSITY of FLORIDA

Division of Pediatric Neurology
New Patient Information Form

*This form will help the doctor obtain information relevant to your child's care. Please fill out **both sides** as best you can.*

Patient's name: _____
Medical Record #: _____ Date: _____
Age: _____ Referring Physician: _____
Our doctors will send a report to the referring physician. Please indicate if you want a copy sent to someone else:

☐ Other Physician: _____
Address: _____
City: _____ State: _____ Zip: _____

☐ Yourself

☐ Other: _____

Please state the main reason for this visit. *Just state your main symptom(s) or concerns; for example, "headache" or "trouble walking." Do not include details of your history or testing. You will have ample opportunity to give the doctor the complete story. On the reverse side of this form, you can check off specific symptoms.*

Medical/Surgical History: *Please check any diseases or surgeries that your child has had and indicate the year of onset/surgery:*

Disorder	*Onset*
☐ Heart Disease	_____
☐ Atrial Fibrillation	_____
☐ Blood clots	_____
☐ Stroke	_____
☐ Epilepsy	_____
☐ Anxiety	_____
☐ Depression	_____
☐ OCD	_____
☐ ADD/ADHD	_____
☐ Migranes	_____
☐ Kidney failure	_____

Disorder	*Onset*
☐ Reflux (GERD)	_____
☐ Asthma	_____
☐ Diabetes	_____
On insulin? Yes No	
☐ Cancer	_____
Location	*Year*
_____	_____
☐ Sleep disorder	_____
Trauma	
☐ Head	_____
☐ Neck	_____
☐ Other	_____

Surgery	Date
☐ Heart	_____
☐ Appendix	_____
☐ Tonsils	_____
☐ Cancer *(fill in type)*	
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ Bladder	_____
☐ Brain	_____
☐ Neck	_____

Surgery	Date
Other surgeries not listed:	
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____
☐ _____	_____

Additional important medical history: _____

Social History:

Are parent(s):
- ☐ Single
- ☐ Married
- ☐ Divorced

Patient lives with:
- ☐ Mom
- ☐ Dad
- ☐ Grandparent
- ☐ Legal Guardian
- ☐ Foster family
- ☐ Other: _____

Siblings? (give numbers)
Brothers: _____
Sisters: _____

Current grade: _____

Current grade level: _____

Which school do you attend?
_____

Please continue on reverse side

Family information

Mother's name: _____ Father's name: _____

Occupation: _____ Occupation: _____

Work number: _____ Work number: _____

Highest educational level: _____ Highest educational level: _____

Pregnancy/Birth History

Mother's age at birth: _____ Birth order of patient: _____ Is child adopted: ☐ Yes ☐ No

Number of pregnancies:_____ Number of births: _____ Number of abortions: _____ Number of miscarriages:_____

Were any medicines or drugs taken during pregnancy? ☐ Yes ☐ No

If yes, which medicines? Please list/explain: _____

_____

Did smoking occur during the pregnancy? ☐ Yes ☐ No

If yes, please list how much/often: _____

Was alcohol consumed during the pregnancy? ☐ Yes ☐ No

If yes, please list how much/often: _____

Did any of the following occur during pregnancy? (Please check all that apply)

☐ decreased fetal movement	☐ morning sickness	☐ swelling	☐ ultrasounds
☐ operations	☐ high fever	☐ amniocentesis	☐ stressful events
☐ special diet	☐ X-ray	☐ hospitalization	☐ significant trauma
☐ stress test	☐ accidents	☐ vaginal bleeding	☐ diabetes
☐ toxemia	☐ unusual worries	☐ high blood pressure	☐ premature labor

Please explain the items you checked along with anything not listed: _____

_____

_____

How long was the pregnancy? _____ Birthplace/hospital: _____

Was the delivery *(please check one)*: ☐ vaginal ☐ breech (feet first) ☐ C-section ☐ Do not know

Child's birth weight? _____ Apgar score: _____

Did the baby go home with mom from the hospital? ☐ Yes ☐ No ☐ Do not know

Did the baby stay in the intensive Care Unit (ICU)? ☐ Yes ☐ No ☐ Do not know

Did the baby stay in the nursery? ☐ Yes ☐ No ☐Do not know

Were any medicines/drugs given to the baby in the hospital? ☐ Yes ☐ No ☐ Do not know

If yes, please list/explain: _____

_____

Were there any complications during delivery/while in the hospital? (infections, jaundice, cyanosis, apnea, vomiting/feeding difficulties, irritability, excessive weight loss, congenital anomalies, etc.) ☐ Yes ☐ No ☐ Do not know

If yes, please list/explain: _____

_____

Family Medical History – *For each of the disorders listed below, indicate in the column titled* ***"Reationhipl"*** *which family member(s) had the illness, using the abbreviations listed.*

Relationship Abbreviations:	
M	Mother
F	Father
B	Brother
S	Sister
GM	Grandmother
GF	Grandfather
O	Other

Relationship	**Disease**	**Relationship**	**Disease**
	ADD/ADHD		High blood pressure
	Bipolar		Diabetes
	Schizophrenia		Cancer
	Tics/Tourette		Dystonia
	Muscle problem		Parkinson's
	Stroke		Neuropathy
	Heart disease		Tremors

Allergies: *Please list any medications to which your child is allergic, and state the nature of the reaction.*

Medication	*Reaction*

Medications: *List here,* ***or provide the doctor/nurse with a complete list.***

Medication	*Dose*	*Frequency*	*Medication*	*Dose*	*Frequency*

Review of symptoms: *Please check any symptoms that your child has recently experienced or you have concerns about:*

☐ Headache	☐ Trouble sleeping	☐ Poor appetite	☐ Over 10 lbs weight loss	☐ Arthritis
☐ Neck pain	☐ Daytime drowsiness	☐ Nausea	☐ Over 10 lbs weight gain	List other symptoms:
☐ Back pain	☐ Fainting/Blackouts	☐ Vomiting	☐ Pain on urination	☐ _____
☐ Pain in limbs	☐ Seizures/epilepsy	☐ Diarrhea	☐ Trouble starting urine	☐ _____
☐ Joint pain	☐ Memory Loss	☐ Constipation	☐ Trouble holding urine	☐ _____
☐ Stomach pain	☐ Hallucinations	☐ Bloody/tarry stool	☐ Blood in urine	☐ _____
☐ Other pain	☐ Confusion	☐ Chest pain	☐ Urinating often	☐ _____
☐ Weakness	☐ Nervousness	☐ Shortness of breath	☐ Premature breast	☐ _____
☐ Muscle cramps	☐ Irritability	☐ Persistent cough	growth	☐ _____
☐ Numbness/tingling	☐ Anxiety	☐ Coughing up blood	☐ Rash	☐ _____
☐ Vision problems	☐ Depression/sadness	☐ Ankle swelling	☐ Fever/chills	☐ _____
☐ Hearing difficulty	☐ Fatigue	☐ Trouble sleeping flat	☐ Unusual thirst	☐ _____
☐ Trouble swallowing	☐ Runny nose	☐ Swollen lymph nodes	☐ Lightheaded on standing	☐ _____
☐ Speech delay	☐ Excessive sneezing	☐ Dizziness	☐ Vertigo (spinning)	☐ _____

Thank you for your assistance. Patient's signature: _____ Date: _____

I have reviewed this history with the patient. Physician's signature: _____ Date: _____