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.

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:

<table>
<thead>
<tr>
<th>Disorder</th>
<th>Onset</th>
<th>Disorder</th>
<th>Onset</th>
<th>Surgery</th>
<th>Date</th>
<th>Surgery</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td></td>
<td>Reflux (GERD)</td>
<td></td>
<td>Heart</td>
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<tr>
<td>Atrial Fibrillation</td>
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<td>Asthma</td>
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<td>Appendix</td>
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<td>Tonsils</td>
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<tr>
<td>Blood clots</td>
<td></td>
<td>Diabetes</td>
<td></td>
<td>Cancer (fill in type)</td>
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<tr>
<td>Stroke</td>
<td></td>
<td>Cancer</td>
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<td></td>
<td>Bladder</td>
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<tr>
<td>Epilepsy</td>
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<td>Sleep disorder</td>
<td></td>
<td>Brain</td>
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<tr>
<td>Anxiety</td>
<td></td>
<td>Trauma</td>
<td></td>
<td>Neck</td>
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<tr>
<td>Depression</td>
<td></td>
<td>Head</td>
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<tr>
<td>OCD</td>
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<td>Neck</td>
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<tr>
<td>ADD/ADHD</td>
<td></td>
<td>Other</td>
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<tr>
<td>Migranes</td>
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<td>Kidney failure</td>
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</tbody>
</table>

Additional important medical history:

Social History:

Are parent(s):

- [ ] Single
- [ ] Married
- [ ] Divorced

Patient lives with:

- [ ] Mom
- [ ] Dad
- [ ] Grandparent
- [ ] Legal Guardian
- [ ] Foster family
- [ ] Other:

Sibling(s) (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: ___________________________

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 “Relationship” which family member(s) had the illness, using the abbreviations listed.

<table>
<thead>
<tr>
<th>Relationship</th>
<th>Disease</th>
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<th>Disease</th>
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<tbody>
<tr>
<td>M Mother</td>
<td>ADD/ADHD</td>
<td>High blood pressure</td>
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<td>F Father</td>
<td>Bipolar</td>
<td>Diabetes</td>
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<td>B Brother</td>
<td>Schizophrenia</td>
<td>Cancer</td>
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<td>S Sister</td>
<td>Tics/Tourette</td>
<td>Dystonia</td>
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<td>GM Grandmother</td>
<td>Muscle problem</td>
<td>Parkinson’s</td>
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<td>GF Grandfather</td>
<td>Stroke</td>
<td>Neuropathy</td>
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<tr>
<td>O Other</td>
<td>Heart disease</td>
<td>Tremors</td>
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</table>

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

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<thead>
<tr>
<th>Medication</th>
<th>Reaction</th>
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**Medications:** List here, or provide the doctor/nurse with a complete list.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
<th>Medication</th>
<th>Dose</th>
<th>Frequency</th>
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</table>

**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/terry 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: ____________