CAREMOUNT MEDICAL

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Pediatric Neurology

Patient Name: _____ Date of Birth: _____

Referring Physician: _____ City/State: _____

Primary Care Physician (PCP) & Practice: _____

Chief Complaint/Reason for Visit: _____

History of Present Illness (HPI) **Please list Location, Quality, Severity, Duration, Timing, Context, Modifying Factors of Associated Signs/Symptoms**	
Past Medical History (PMH) **Please list any prior major illness, surgeries, and hospitalizations**	

Please list **Current Medications**:

Medication	Dose/Frequency	Date Started	For what condition	Prescribing Physician	Comments

Please list **Medication Allergies**: _____

Please list all **significant medications** patient has been on in the **past**:

Medication	Dose/Frequency	For what condition	Date started	Date stopped	Reason for stopping	Comments

Past Medical History

A. Pre and Perinatal History
Did mother use any of the following during her pregnancy?

Beer Wine Hard Liquor Cigarettes Medications (Please list): _____

Were there any pregnancy complications? No Yes

If yes, please describe: _____

_____

Was there any fetal distress during labor? _____

Did mother have any medical/psychiatric conditions prior to or during the pregnancy? No Yes

If yes, please list: _____

How many weeks gestation was the child born? _____

Where was the child born? (Name, City, State) _____

Type of Delivery: Vaginal → No Yes _____

C/Section → Reason _____

Birth Weight: _____

Were there any postnatal medical problems? _____

B. Infancy
Did any of the following problems occur during infancy?

Poor feeding Vomiting Colic Excessive Sleepiness Poor sleep

Was he/she a difficult baby? _____

How would you rate your child's activity level as a toddler?

Very Active Active Average Less Active Very Inactive

What age were these developmental milestones achieved? Walked_____Spoke first words:_____

Strung two or more words together: _____

Did you have any concerns about his/her development? _____

Educational/Social History

Patient's current grade level: _____

Has your child ever received psychological testing, either privately or by the school district? Yes/No. If so, please obtain the results of these tests. Please summarize in your own words the results of this testing and the recommendations that were made to you.

_____
_____
_____
_____
_____

Has your child had any of the following evaluations and/or interventions? (Please check all that apply)

Child Neurology _____ Child Psychiatry _____

Child Psychology _____ Child Psychotherapy _____

Please list patient's extracurricular activities: _____

Patient Substance Use (If Applicable):
Alcohol use: No: ____ Yes: ____ Amount: _____
Tobacco use: No: ____ Yes: ____ Amount: _____
Other information you think I should know: _____
_____

Family History

Father's Age: _____ Education level:_____Occupation: _____
Mother's Age: _____ Education level:_____Occupation: _____

Please list siblings (Age/Gender):_____

Parents' Marital Status: Married Separated Divorced Remarried Widowed

Do any family members have any of the following conditions?
Please circle all that apply and list affected members/relatives

ADHD: _____
Learning disability/difficulties: _____
Speech delay: _____
Developmental delay: _____
Mental retardation: _____
Autism/PDD: _____
Seizures/Epilepsy: _____
Cerebral Palsy: _____
Alcohol/Substance abuse: _____

Hearing loss: _____
Visual loss: _____
Tourette's Syndrome/tic disorder: _____
_____
Depression: _____
Bipolar disorder: _____
Obsessive-compulsive disorder: _____
Anxiety: _____
Headaches/Migraines: _____

Other: _____

REVIEW OF SYSTEMS
(Please check all that apply, Please check "negative" if nothing applies)

1. Constitutional □ Negative
- ☐ Fevers
- ☐ Weight loss or gain
- ☐ Difficulty Sleeping/ Night Sweats
- ☐ Excessive Tiredness or Fatigue
- ☐ Loss of appetite

2. Eyes □ Negative
- ☐ Flashing Lights or "Stars"
- ☐ Blind Spots
- ☐ Double Vision

3. ENT □ Negative
- ☐ Earache or discharge
- ☐ Nose bleeds
- ☐ Ringing in the ears
- ☐ Difficulty hearing
- ☐ Sinusitis
- ☐ Hoarseness

4. Respiratory □ Negative
- ☐ Cough
- ☐ Coughing up blood
- ☐ Wheezing

5. Cardiovascular □ Negative
- ☐ Chest pain
- ☐ Swelling of hands, feet, legs or face
- ☐ Squeezing or tightness in chest
- ☐ Palpitations or fluttering of heart
- ☐ Shortness of breath at rest
- ☐ Shortness of breathing walking

6. Gastrointestinal □ Negative
- ☐ Nausea or vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal Pain
- ☐ Vomiting blood
- ☐ Very light or dark stool
- ☐ Bleeding from rectum

7. Integumentary □ Negative
- ☐ Rash
- ☐ Bruising
- ☐ Itching

8. Genitourinary □ Negative
- ☐ Blood in or very dark urine
- ☐ Urinary incontinence
- ☐ Getting up at night to urinate
- ☐ Burning with urination
- ☐ Unusual urgency to urinate
- ☐ Other :_____

9. Musculoskeletal □ Negative
- ☐ Arthritis
- ☐ Bone pain
- ☐ Neck pain
- ☐ Low back pain
- ☐ Joint Pain

10. Endocrine □ Negative
- ☐ Diabetes
- ☐ Thyroid
- ☐ Menstrual problems

11. Hematological □ Negative
- ☐ Anemia
- ☐ Bleeding

12. Neurological □ Negative
- ☐ Headaches
- ☐ Numbness or tingling
- ☐ Loss of consciousness
- ☐ Dizziness
- ☐ Fainting spells
- ☐ Double vision
- ☐ Difficulty swallowing
- ☐ Coordination difficulties
- ☐ Sleep disturbance
- ☐ Loss of strength
- ☐ Learning difficulties
- ☐ Other:_____

13. Psychiatric □ Negative
- ☐ Depression
- ☐ Anxiety

14. Allergy/Immunology □ Negative
- ☐ Foods
- ☐ Seasonal
- ☐ Other:_____