Center for Neurosciences

PEDIATRIC MEDICAL CONSULTATION FORM

PATIENT'S NAME: _____ Date: _____

Age: _____ DOB: _____ Height: _____ Weight: _____

PARENT INFORMATION

Father's Name: _____ Mother's Name: _____

Father's Age: _____ Occupation: _____ Mother's Age: _____ Occupation: _____

Education: _____ Education: _____

Do both parents live in the home? ❑ Yes ❑ No List all brothers and sisters:

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Referring physician ❑ Yes ❑ No _____ PCP ❑ Yes ❑ No _____ Anyone else? _____

What is the reason for your visit today? _____

_____

_____

_____

_____

_____

BIRTH HISTORY

What was the patient's birth weight? _____ What number pregnancy was this for the mother? _____

What number birth was this for the mother? _____ Miscarriages? _____

During the pregnancy with this child were there any problems? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Did mother see a physician regularly during pregnancy? ❑ Yes ❑ No Did mother smoke during pregnancy? ❑ Yes ❑ No

Did mother use alcohol or recreational drugs during pregnancy? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Did mother take any medications during pregnancy? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

CONTINUE ON BACK

PATIENT'S NAME: _____ DOB: _____

How long did the pregnancy last? _____

During labor and delivery were there any complications (i.e., cesarean section)? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Were there any birth defects noted? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

Following delivery did the baby have any problems while in the nursery? ❑ Yes ❑ No

If yes, please describe: _____

_____

_____

How long did the baby stay in the hospital after birth? _____

DEVELOPMENTAL HISTORY

When did your child do the following:

Roll front to back?	_____ month(s)
Sit without support?	_____ month(s)
Walk without support?	_____ month(s)
Speak first word other than mama/dada?	_____ month(s)
Use two word phrases?	_____ month(s)

Have there been any PROBLEMS with:

Social development?	❑ Yes ❑ No
Recognizing parents?	❑ Yes ❑ No
Playing patty-cake?	❑ Yes ❑ No
Playing alongside other children?	❑ Yes ❑ No
Playing with other children interactively?	❑ Yes ❑ No

SCHOOL HISTORY

If your child attends school, what grade is he/she in? _____

_____

Is your child in special education? _____

_____

How is your child performing in school? _____

_____

Are there any current PROBLEMS with behavior related to:

Relationship with parents/other family?	❑ Yes ❑ No
Discipline at home?	❑ Yes ❑ No
Making or getting along with friends?	❑ Yes ❑ No
Irritability or temper tantrums?	❑ Yes ❑ No
Overactivity or hyperactivity?	❑ Yes ❑ No
Aggression or destructive behavior?	❑ Yes ❑ No
Short attention span?	❑ Yes ❑ No
Distractibility?	❑ Yes ❑ No
Attention-seeking behavior?	❑ Yes ❑ No

MEDICAL HISTORY

Please describe any hospitalizations, surgeries, seizures or head injuries (only if the injury was associated with change in consciousness):

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

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Please list all medications the child takes: ❑ None

Medication	Dosage	Frequency	Medication	Dosage	Frequency
1.			4.		
2.			5.		
3.			6.		

Please list all medication allergies the child may have: ❑ None

Allergy to:	Reaction:	Allergy to:	Reaction:
1.		3.	
2.		4.	

Are the child's immunizations up to date? ❑ Yes ❑ No

Have there been any adverse reactions to immunizations? ❑ Yes ❑ No

REVIEW OF SYSTEMS

Does the child now have or ever had the following problems:		PLEASE DESCRIBE ANY "YES" ANSWERS
Ears, Eyes, Nose, Throat (e.g. hearing impairment, trouble feeding/swallowing, ear infections, tonsillitis)	❑ Yes ❑ No	
Heart Problems (e.g. murmur, irregular rhythm, hypertension)	❑ Yes ❑ No	
Lung problems (e.g. wheezing, asthma, pneumonia, valley fever, tuberculosis)	❑ Yes ❑ No	
Kidney/Bladder Problems (e.g. problems with urination, urinary tract infections, kidney disease)	❑ Yes ❑ No	
GI Problems (e.g. constipation, diarrhea, frequent vomiting, poor weight gain, G tube)	❑ Yes ❑ No	
Liver Problems (e.g. hepatitis)	❑ Yes ❑ No	
Hormone/Endocrine Problems (e.g. thyroid short stature, early puberty, diabetes)	❑ Yes ❑ No	
Neurological Problems (e.g. fainting, dizziness, weakness, numbness, tingling, headaches, tremor, tics, seizures, strokes)	❑ Yes ❑ No	
Mental/Emotional Problems (e.g. depression, severe mood swings, drug or alcohol abuse)	❑ Yes ❑ No	
Toilet Training Problems	❑ Yes ❑ No	
Sleep Problems	❑ Yes ❑ No	
Peculiar Habits	❑ Yes ❑ No	
Skin	❑ Yes ❑ No	
Musculoskeletal (e.g. joints, bones)	❑ Yes ❑ No	
Other Problems (e.g. blood disorders, immune disease)	❑ Yes ❑ No	
Environmental Allergies:	❑ Yes ❑ No	

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FAMILY HISTORY

Please list all serious illnesses the child's blood relatives have had:

Father _____

Mother _____

Brother(s) _____

Sister(s) _____

Among the child's blood relatives have there been any problems with the following? If yes, please describe below and include the relationship to the child.

Developmental disability/mental retardation	❑ Yes ❑ No	Behavioral/psychiatric	❑ Yes ❑ No
Seizures, convulsions, epilepsy	❑ Yes ❑ No	Other neurological problems	❑ Yes ❑ No
Learning problems/ADD/hyperactivity	❑ Yes ❑ No	Problems similar to child's	❑ Yes ❑ No
Headaches/migraines	❑ Yes ❑ No	Autoimmune disorders (e.g. lupus)	❑ Yes ❑ No
Strokes	❑ Yes ❑ No	Genetic/hereditary conditions	❑ Yes ❑ No
Weakness/incoordination	❑ Yes ❑ No		

_____

_____

_____

_____

SOCIAL HISTORY

Have there been any changes at home or school you would like the doctor to know about? ❑ Yes ❑ No

If yes, please describe: _____

_____

Are there any concerns about possible tobacco/alcohol/drug use? ❑ Yes ❑ No Sexual activity? ❑ Yes ❑ No

If yes, please describe: _____

_____

The above information is accurate and complete to the best of my knowledge.

Parent/Guardian _____ Date: _____

OFFICE USE ONLY: MD/PA/NP Signature
I have reviewed the patient history form:

_____ Date: _____