Pediatric Neurology History

Date: ____________________

Child's full name: ____________________

This information, in your own words, will help the physician to understand and treat your child. It will be kept **CONFIDENTIAL**. A report of this and any future visits will only be sent to a doctor and/or school in which you designate.

Name of Referring Doctor: ____________________

Address/Phone: ____________________

Name of School: ____________________

Address/Phone: ____________________

I hereby give permission to send a copy of this report to the above named DOCTOR and/or SCHOOL (Circle either or both).

____________________ (Signature of Parent or Legal Guardian)

CHILD'S NAME (as used at home): ____________________

AGE: ____ years ____ months

REASON FOR COMING (symptoms or complaints): ____________________

AT WHAT AGE DID THIS BEGIN? ____________________

HOW HAS THIS DEVELOPED? OVER WHAT PERIOD OF TIME? (slowly, quickly, always appears the same, etc.):

WHAT TESTS HAVE BEEN DONE AND WHERE? ____________________

WHAT TREATMENTS AND/OR MEDICATIONS HAVE BEEN USED? ____________________

PHYSICIAN SIGNATURE: ____________________

Name: ____

Date of Birth: ____

Pediatric Neurology History Cont'd

FAMILY HISTORY:

Present age of:
MOTHER ____________________
FATHER ____________________
SISTERS ____________________
BROTHERS ____________________

PARENTS: ☐ Married ☐ Separated ☐ Divorced ☐ Other

Who lives at home with this child? ____

____

Have there been similar symptoms with other members of the family? ____________________

Mother's Side: ____

____

Father's Side: ____

____

CHILD'S EARLY HISTORY:

Pregnancy (complications): ____

____

____

Duration (full term, premature, etc.): ____

____

____

Labor and Delivery (complications): ____

____

____

BIRTH WEIGHT _____lbs _____oz

GROWTH AND DEVELOPMENT

______ months — Rolled over
______ months — Sat
______ months — Walked
______ months — First words
______ months — Speech Development

Handedness ☐ Right ☐ Left ☐ Both
Age preference appeared ____________________
Rode a Tricycle __________ years
Rode a Bicycle __________ years

PHYSICIAN SIGNATURE: ____

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Name: ______________________________

Date of Birth: ______________________________

Pediatric Neurology History Cont'd

GROWTH AND DEVELOPMENT CONT'D:

Diagnosed Medical Conditions: ______________________________

Hospitalizations: ______________________________

Surgeries: ______________________________

Current Medications ______________________________

Medication Allergies______________________________

CHILD'S SOCIAL HISTORY (note any special strengths and/or weaknesses):

Daycare/Preschool ______________________________

Kindergarten ______________________________

Grades 1, 2, 3 ______________________________

Grades 4, 5, 6 ______________________________

Grades 7, 8, 9 ______________________________

Grades 10, 11, 12 ______________________________

PHYSICIAN SIGNATURE: ______________________________

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