PEDIATRIC NEUROLOGY MEDICAL HISTORY QUESTIONNAIRE

PAST MEDICAL HISTORY, FAMILY HISTORY, & REVIEW OF SYMPTOMS

Date:_______________

Patient First & Last Name:________________________________ Patient DOB: ____________

Patients Birth Weight: ______ lb ______ oz

	YES	NO		YES	NO
Problems With pregnancy			Vision Problems? (Double, vision, large spots, loss)		
Problems with Delivery?			Hearing problems? (not listing, but hearing)		
Newborn discharge home in 2-3 days?			Frequent choking on liquids?		
Newborn jaundice?			Unclear speech for majority of the time?		
			Staring Spells		
Hospitalized Overnight?			Convulsions?		
Any surgeries?			Takes daytime naps?		
Any chronic medical problems?			Problems settling to Sleep?		
Any daily use prescriptions medicines?			Waking up too frequently?		
Any allergies to medicines?			Numbness or tingling?		
Any allergies to food?			Weakness?		
			Involuntary movements?		
Sat up by 6-7 months of age?			Involuntary Stiffening?		
Walked by 12-13 months of age?			Loss of control of bladder or bowel?		
Understood verbal commands by 18 months?			Blackout spells?		
Combined words by 24 months of age?			Dizziness?		
			Poor appetite?		
Family history of epilepsy?			Fatigue, loss of energy ?		
Family history of migraines?			Problems with smells ?		
Family history of stroke under 50 yrs old?			Anxiety?		
Family History of mental retardation?			Depression?		
Family history of cerebral palsy?			Aggressive behaviors?		
Family history of children dying under 6 years?			Disruptive or oppositional behaviors?		
Father and mother related?			Poor attention in school?		
Single parent			Frequent chest pain?		
Other children in household?			Frequent problems breathing?		
Enrolled in Special Education?			Frequent belly pains?		
Recent academic problems?			Chronic diarrhea or constipation?		
Is Child adopted?			Birthmarks?		