KANSAS PEDIATRIC NEUROLOGY

PEDIATRIC NEUROLOGY PATIENT HISTORY FORM

DATE: _____

Patient Name:

PCP: _____

Date of Birth:

Age: _____

Hand Dominance: ☐ RIGHT ☐ LEFT ☐ AMBIDEXTROU (BOTH)

Reason Patient is here to see the doctor?

_____

PREGNANCY / BIRTH PROBLEMS

Problems during pregnancy or delivery of the patient:

_____

Birth Hospital: _____

Duration of Pregnancy(how long was the mother pregnant?) _____ months

☐ VAGINAL DELIVERY ☐ C-SECTION Reason for C-section _____

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

Has the patient had surgery? ☐ YES ☐ NO

If yes, name of the hospital, surgery date and type of surgery:

_____

Has the patient ever been admitted to and slept in a hospital? ☐ YES ☐ NO

If yes, what was the reason for the hospital admission? _____

Approximate date of the hospital admission: _____

Name of the hospital: _____

Has the patient even been in the ER: _____

If yes, what was the reason: _____

PLEASE REMEMBER TO BRING ALL MEDICATIONS WITH YOU WHEN YOU COME TO SEE THE DOCTOR

Approximate date of ER visit: _____

Name of hospital: _____

LEARNING / SCHOOL

Does the patient have speech delay: ☐ YES ☐ NO

At what age did the patient: Sit alone: _____

Walk: _____

Toilet-Trained: _____

Say "Mama, Dada": _____

Name of school patients attends: _____

Grade level: _____

Is there an IEP in place: ☐ YES ☐ NO

Is the patient missing the school days: ☐ YES ☐ NO

MEDICATIONS

Is the patient taking any daily medications? ☐ YES ☐ NO

NAME OF MEDICATION	DOSE

Is there anyone on either side of the family with similar issues? ☐ YES ☐ NO

If yes, please list the relationship and illness (example: sister with migraines) _____

_____

Has the patient had any of the tests completed

MRI: ☐ YES ☐ NO EEG: ☐ YES ☐ NO

If yes, location and date: _____

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