Neurosurgical Associates, LTD

Health History Form - Pediatrics

Patients height? ____

Patients weight? ____

Hand Preference ☐R ☐L ☐B

Patient Name:

Birth Date: **Gender:**

Appt Date: **MRN:**

Rendering Provider:

Staff to complete

BP ____

BMI ____

OFC ____

Injury / Illness Information

Chief Complaint: ____

How long have you had this problem? ____ How did symptoms start? ☐suddenly ☐gradually ☐chronic

Have you experienced similar problems in the past? ☐ No ☐ Yes If injury related, date of injury: ____ / ____ / ____

REFERRING PHYSICIAN *PRIMARY PHYSICIAN*

Referring Physician ____ **Primary Physician** ____

Please check and include last date of treatment for any of the following (mm/yyyy) ☐ **None**

	mm/yyyy	Back	Neck	Brain	Abdomen
☐ MRI		☐	☐	☐	
☐ CT		☐	☐	☐	
☐ X-Rays		☐	☐	☐	☐
☐ Ultrasound				☐	☐
☐ Angiogram				☐	

	mm/yyyy	Upper Extremity	Lower Extremity
☐ EMG		☐	☐

	Name of facility?
☐ Physical Therapy	
☐ Chiropractic	
☐ Speech Therapy	
☐ Urodynamics	
☐ Nutrition Services	
☐ Occupational Therapy	

PAST SURGICAL HISTORY (list any **surgery** the child has had with the approximate year (yyyy) ☐ **None**

☐ Appendectomy		☐ Eye Surgery		☐ Tonsillectomy	
☐ Baclofen Pump		☐ Gastrostomy Tube		☐ Orthopedic Surgery (Hip)	
☐ Bladder Surgery		☐ Hernia Repair		☐ Orthopedic Surgery (Leg/Foot)	
☐ Colostomy		☐ Lumbar Puncture			
☐ Ear Tubes		☐ Shunt Tap			
☐ Back Surgery		☐ Brain Surgery		☐ Neck Surgery	
Surgical Procedure:		Surgical Procedure:		Surgical Procedure:	
☐ Back Surgery		☐ Brain Surgery		☐ Other	
Surgical Procedure:		Surgical Procedure:		Surgical Procedure:	

Please continue on other side

MEDICAL HISTORY Please put a check next to the disease below if the child currently has, or has been diagnosed with in the past

- ☐ Allergies (Seasonal)
- ☐ ADD/ADHD
- ☐ Asthma
- ☐ Autism
- ☐ Behavior Problems
- ☐ Blindness
- ☐ Chiari Malformation
- ☐ Cancer
- ☐ Depression
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ GERD
- ☐ Heart Disease
- ☐ HIV
- ☐ Hearing Impairment
- ☐ Hydrocephalus
- ☐ Irritable Bowel Disease
- ☐ Migraine Headaches
- ☐ Neurogenic Bladder
- ☐ Neurogenic Bowel
- ☐ OCD
- ☐ Prematurity
- ☐ Kidney Disease
- ☐ Retinopathy
- ☐ Seizure Disorder
- ☐ Spina Bifida
- ☐ Stroke (CVA)
- ☐ Subdural Hematoma
- ☐ Thyroid Disease
- ☐ Tethered Cord Syndrome

Other _____

Other _____

Type of cancer: _____

MEDICATIONS ☐ NONE

(List all medications the child is currently taking including herbal and over-the-counter medications)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ALLERGIES ☐ NONE

Medications child is allergic to:

_____

_____

_____

Other allergies (food, seasonal, etc.)

_____

_____

Is the child allergic to?

- ☐ Adhesive Tape
- ☐ Latex
- ☐ CT Contrast/Kidney Dye/Iodine?
- ☐ Gadolinium/MRI Contrast?

SOCIAL HISTORY

Lives primarily with:

- ☐ Mother
- ☐ Father
- ☐ Grandmother
- ☐ Grandfather
- ☐ Foster Mother
- ☐ Foster Father
- ☐ Aunt
- ☐ Uncle

Number of siblings? _____

TOBACCO USE

Is your child exposed to second hand smoke? ☐ Yes ☐ No

EDUCATION:

Grade in School: _____

Does your child have a learning disability?

- ☐ IEP in place
- ☐ math
- ☐ reading
- ☐ speech
- ☐ Title I

Does your child like school? ☐ No ☐ Yes

Performing: ☐ Below grade level

☐ At grade level

☐ Above grade level

VACCINATION

Has your child received an influenza vaccination this year?

☐ No ☐ Yes Date _____

Please continue on other side

FAMILY HISTORY Please indicate if patient's mother, father or sibling has or had any of the following diseases or it was their cause of death (COD)

☐ Patient is adopted

	Mother		Father		Sister(s)		Brother(s)	
	Now	*COD*	*Now*	*COD*	*Now*	*COD*	*Now*	*COD*
Alcoholism	☐	☐	☐	☐	☐	☐	☐	☐
Aneurysm/Brain	☐	☐	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐	☐	☐
Heart disease	☐	☐	☐	☐	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐	☐	☐	☐	☐
High cholesterol	☐	☐	☐	☐	☐	☐	☐	☐
Kidney disease	☐	☐	☐	☐	☐	☐	☐	☐
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐
Obesity	☐	☐	☐	☐	☐	☐	☐	☐
Psychological Disorder	☐	☐	☐	☐	☐	☐	☐	☐
Seizures	☐	☐	☐	☐	☐	☐	☐	☐
Stroke (CVA)	☐	☐	☐	☐	☐	☐	☐	☐

Other family history

REVIEW OF SYSTEMS (Please check if the child had any of the following in the last 6 months) ☐ NONE

- ☐ Fevers
- ☐ Fatigue
- ☐ Weight loss
- ☐ Rash
- ☐ Hives
- ☐ Cancer
- ☐ Bruising
- ☐ Easy bleeding
- ☐ Swollen glands
- ☐ Tremors
- ☐ Hair loss
- ☐ Excessive thirst
- ☐ Blurry vision
- ☐ Visual loss
- ☐ Double vision
- ☐ Ringing in ears
- ☐ Hearing loss
- ☐ Trouble swallowing
- ☐ Chest pain
- ☐ Heart Palpitations
- ☐ Leg swelling
- ☐ Coughing
- ☐ Sleep apnea
- ☐ Short of breath
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Muscle Weakness
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Dizziness
- ☐ Seizures
- ☐ Headaches
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia

Other:

Thank you for completing our patient information form