CARE *that*
CHANGES LIVES.

PEDIATRIC NEUROLOGY NEW PATIENT VISIT FORM

Patient Name: _____ Patient Gender: ☐ Male ☐ Female
Last First MI

Date of Birth: ____/____/_____ Age: _____ Patient's hand preference: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

The name of the person filling out the questionnaire: _____

Relationship to Patient: _____

Who referred you to us?: _____

Why is the child being seen?: _____

Was the child seen by anyone else for this problem previously? ☐ YES ☐ NO If yes, who? _____

Did your child have any *prior* testing for this problem? ☐ YES ☐ NO If yes:

Test name (e.g. MRI, ET, EEG)	When was it done?	Where was it done?	What did it show?

Did your child have any *prior* treatment for this problem? ☐ YES ☐ NO If yes:

Medication or intervention	Dose	How often?	Did it work?	Any side effects?	Why was it stopped?

Does your child currently take *any* medications (including over the counter (such as Tylenol), vitamins, food supplements, special diet, etc.)? ☐ YES ☐ NO If yes:

Medication	Dose	How often	For what indication?

Is your child involved in any therapies? ☐ YES ☐ NO

If yes, what/how often? ☐ PT _____ ☐ OT _____ ☐ Speech Therapy _____

Does your child have any allergies? ☐ YES ☐ NO If yes:

What is the patient allergic to?	**What kind of a reaction?**

Does your child *currently* have any other medical problems? ☐ YES ☐ NO If yes:

Illness	**Year Diagnosed**

Did your child have any medical problems in the *past*? ☐ YES ☐ NO If yes:

Illness/surgery/admission to a hospital (overnight)	**Year**

Was the pregnancy normal (please refer to the mother's pregnancy with the patient)? ☐ YES ☐ NO Please, specify the details:

How many pregnancies did the mother have, including this one, prior to the patient being born? (include abortions, miscarriages, molar pregnancy, etc.)	
Did the mother have any miscarriages? If yes, how many and at what gestational age (how many weeks was she pregnant)?	
By any chance, could the mother and father be related by blood?	
Any infertility treatments? (If yes, who was treated- mother or father?)	
Was the pregnancy naturally conceived (vs. in vitro)?	
Any medications during pregnancy? (if yes, what)	
Any illnesses during pregnancy? (if yes, what)	
Any alcohol or recreational drugs during pregnancy? (if yes, what, how much and how often?)	
Any complications of pregnancy?	
Were the baby movements normal in utero?	

Was the delivery normal (please refer to the mother's delivery with the patient)? ☐ YES ☐ NO Please, specify the details:

How many deliveries did the mother have, including this one, when the patient was born?	
How many weeks was the mother pregnant at delivery?	
What kind of delivery was it? (circle one)	Vaginal: spontaneous or induced C-section: scheduled, unscheduled, or emergency
If it was a C-section, why was it necessary?	
Any assistance used? (check one)	☐ None ☐ Forceps ☐ Vacuum ☐ Both
Any complications?	
Do you happen to know Apgar scores (two numbers in between 1 and 10, assigned at 1st and 5th minute of life)? If yes, what were they?	
What was the birth weight?	
Did your child require resuscitation (e.g., chest compressions, breathing machine)?	
Did your child require a stay in a Neonatal Intensive Care Unit? (If yes, for how long?)	
Did your child go home on time from the hospital after delivery? If no, how long after?	☐ YES ☐ NO _____

Was your child's development normal? ☐ YES ☐ NO Please, specify the age at which developmental milestones were acquired.

Milestone	**Age**
Rolling (front to back and back to front) Typically at 3 months of age	
Sitting unsupported Typically at 6 months of age	
Crawling Typically at 9 months of age	
Pulling up to standing Typically at 11 months of age	
Walking independently Typically at 12 months of age	
First words with meaning (ex., "mama" specifically to the mother – not just babbling) Typically at 12 months of age	

Is there a Family History of neurological problems (including but not limited to: seizures, developmental delays, learning problems, headaches (even if mild), car sickness, seizures/ febrile seizures, tics, tremors, wheelchair bound, etc.)? ☐ YES ☐ NO

If yes, what disorders?

Relationship to the Patient	**Disorder**

Does the patient have any brothers or sisters (biological; include half-siblings)? ☐ YES ☐ NO If yes:

Brother or Sister?	**Age**	**Name**	**Any Health Problems?**

Social History:

With whom does the patient live?	
Does the patient go to school/daycare?	
If yes, what school/daycare?	
If applicable, what grade?	
If applicable, how is the patient doing at school?	
If applicable, does the patient have a special education plan?	
Does the patient smoke?	
Does the patient consume alcohol? If yes, how much?	
Does the patient use recreational drugs? If yes, what?	

Review of Systems: Does your child have any of the following conditions? (Please circle which, if any)

1. Constitutional:	Poor appetite	Fevers	Night sweats	Unintentional weight loss	Fatigue
2. Neurological:	Numbness	Tingling	Headache	Car sickness	Seizures
3. Eyes:	Wears glasses	Changes in vision	Eye pain		
4. Ear/nose/throat:	Hearing difficulties	Ear pain	Dry mouth	Dizziness	
5. Cardiovascular:	Irregular heartbeat	Lightheaded	Ankle swelling	Loss of consciousness (Passing out)	
6. Respiratory:	Cough	Wheezing	Shortness of breath		
7. Gastrointestinal:	Nausea	Vomiting	Abdominal pain	Constipation	Diarrhea
8. Urinary:	Kidney stones	Pain during urination		Incontinence	
9. Genital/reproductive:	Sexually active	Heavy or irregular periods		Pregnancy	
10. Muscular-skeletal:	Scoliosis	Neck or back pain	Indented chest wall	Joints too loose	
11. Skin	Birth marks	Rashes Moles	Dry Skin	Sensitivity to sun light	
12. Phychology/psychiatry	Sadness Tearfulness	Fears ADHD	Hallucinations	Difficulty sleeping	Autism
13. Endocrine:	Excessive thirst	Heat intolerance	Diabetes	Thyroid or growth problems	
14. Hematologic:	Easy bleeding/brusing		Swollen lymph nodes		
15. Immunologic:	Allergic reactions	Skipped vaccinations			
16. Pain:	On a scale of 0-10 (0=no pain: 10=worst pain imaginable), how would you rate it?_____				

What do you hope to achieve from this visit? _____
_____
_____

Do you have any specific questions for the doctor? _____
_____
_____

Parent or Guardian Signature: _____ Date: _____

ROCHESTER REGIONAL HEALTH
Neuroscience Institute

Pediatric Neurology
1425 Portland Ave
Lobby Level
Rochester, NY 14621
585.922.4111