NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

PEDIATRIC NEUROLOGY

NAME____DATE:___________________
GRADE: ____ AGE: ___________________

CHIEF COMPLAINT:
____
____
____
____
How long have the symptoms been present? __________________________________
Is there anything that makes the symptoms worse? ____________________________
Is there anything that makes the symptoms better? ____________________________

NEUROLOGICAL SYMPTOMS:

Headache	Yes /No		Tics/Habits	Yes /No	
Fainting Spells	Yes /No		Dizziness	Yes /No	
Seizures	Yes /No		Numbness	Yes /No	
Severe head injury	Yes /No		Memory difficulty	Yes /No	
Sudden visual loss	Yes /No		Depression	Yes /No	
Double vision	Yes /No		Neck pain	Yes /No	
Low back pain	Yes /No				

Have you ever consulted a neurologist before? Yes /No
Are you right-handed or left-handed? Right /Left

PAST MEDICAL HISTORY:

High blood pressure	Yes /No	Diabetes	Yes /No
Heart disease	Yes /No	Lyme disease	Yes /No
Asthma	Yes /No	Thyroid disease	Yes /No
Environmental Allergies	Yes /No		
Vaccinations up-to-date	Yes /No		

DEVELOPMENTAL HISTORY:
Born: Full term Premature _____ weeks/ months/ days
Vaginal delivery C-section Emergency
Walked at age____ First words at age_____

SURGICAL HISTORY:
Ear tubes: ____
Tonsillectomy: ____
Adenoidectomy: ____
Other: ____

HOSPITALIZATIONS:____
____
____
____
____

(PLEASE COMPLETE OTHER SIDE)

MEDICATIONS: (include dosage and frequency)

1.______________	6.______________
2.______________	7.______________
3.______________	8.______________
4.______________	9.______________
5.______________	10.______________

ALLERGIES TO MEDICATIONS:

None Penicillin Sulfa drugs X-ray dye

Other: ______________________________

SOCIAL HISTORY:

Smoking: Yes /No Amount? _______________

Alcohol: Yes /No Occasional Daily Amount? _____________

Living arrangement: Both parents Mother Father Other

School and grade: ______________________________

FAMILY HISTORY: (indicate any that apply)

Migraine	**Seizures**	**Brain tumor**	**Febrile Seizures**
Parkinson's	**Alzheimer's**	**Stroke**	**ADHD**
Nerve disease	**Muscle diseases**	**Tics**	**Multiple sclerosis**
Mental retardation	**Depression**	**Mental Illness**	**Learning disabilities**
Hypertension	**Heart Disease**	**Diabetes**	

Siblings? How many__________________

REVIEW OF SYSTEMS: (indicate any that apply)

CONSTITUTIONAL:	none	fever weight loss weight gain extreme fatigue
		fainting spells falls
SKIN:	none	rash skin cancer birthmarks (<5)
EYES:	none	pain in eyes wear glasses/contacts
ENT:	none	ringing in ears sinus infections grind teeth
		difficulty swallowing pain with swallowing
CARDIOVASCULAR:	none	chest pain palpitations irregular beat murmur
RESPIRATORY:	none	shortness of breath chronic cough wheezing
GASTROINTESTINAL:	none	nausea vomiting diarrhea constipation abd. pain
GENITO-URINARY:	none	incontinence urgency impotence
HEMATOLOGY:	none	bleeding tendency anemia easy bruising
GYNECOLOGY:	none	loss of menstrual period (excluding pregnancy)
PSYCHIATRIC:	none	depression anxiety hallucinations insomnia
MUSCULOSKELETAL:	none	muscle pain joint pain joint swelling stiffness

Patients' Signature: ______________________________Reviewed by MD________

Initials