

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? _____
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		

DEVELOPMENTAL HISTORY:

Born: Full term premature _____ weeks
Vaginal delivery C-section ? Emergency
Walked age _____ First words age _____

SURGICAL HISTORY:

Ear Tubes - _____
Tonsillectomy - _____
Adenoidectomy - _____
Other - _____

HOSPITALIZATIONS:

(PLEASE COMPLETE OTHER SIDE)

