NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

PEDIATRIC NEUROLOGY

NAME: _____ **DATE:** _____
GRADE: _____ **AGE:** _____
SCHOOL: _____

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 ☐**	**Other:**	_____
Vaccinations up-to-date	**Yes ☐ /No ☐**		_____

DEVELOPMENTAL HISTORY:
Born: ☐ **Full term** ☐ **Premature** _____ ☐ **weeks/** ☐ **months/** ☐ **days**
Vaginal delivery ☐ **C-section** ☐ **Emergency/Reason:** _____
Walked at age _____ **First words at age** _____

SURGICAL HISTORY:

Ear tubes:	**Yes ☐ /No ☐**	**Date:** _____
Tonsillectomy:	**Yes ☐ /No ☐**	**Date:** _____
Adenoidectomy:	**Yes ☐ /No ☐**	**Date:** _____

List others w/date: _____

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**

FAMILY HISTORY: (indicate any that apply)

☐ **Migraine**	☐ **Seizures**	☐ **Brain tumor**	☐ **Febrile Seizures**
☐ **Parkinson's**	☐ **Alzheimer's**	☐ **Stroke**	☐ **ADHD**
☐ **Autism**	☐ **Muscle diseases**	☐ **Tics**	☐ **Multiple sclerosis**
☐ **Anxiety**	☐ **Depression**	☐ **Mental Illness**	☐ **Learning disabilities**
☐ **Hypertension**	☐ **Heart Disease**	☐ **Diabetes**	☐ **Bipolar**
			☐ **Development Delays**

Siblings? How many _____

REVIEW OF SYSTEMS: (indicate any that apply)

CONSTITUTIONAL:	☐ none ☐ fever ☐ weight change ☐ extreme fatigue
SKIN:	☐ none ☐ rash ☐ 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 ☐ constipation ☐ abd. pain
GENITO-URINARY:	☐ none ☐ incontinence
HEMATOLOGY:	☐ none ☐ bleeding tendency ☐ easy bruising
GYNECOLOGY:	☐ none ☐ menstrual cycle regular
PSYCHIATRIC:	☐ none ☐ depression ☐ anxiety ☐ hallucinations ☐ insomnia
MUSCULOSKELETAL:	☐ none ☐ muscle pain ☐ joint pain ☐ joint swelling ☐ stiffness

Patients' Signature: _____ **Reviewed by MD**_____
Initials