Pediatric Neurosurgical Specialists

Today's Date _____

Health Questionnaire

Please take a moment to answer each question and complete all areas that apply to your child's health. This information will be reviewed by the physician and will be useful in the evaluation and treatment of your child's condition.

Patient Name _____ Date of Birth _____

Reason for today's visit _____ Age _____ Sex: M☐F☐

Primary Care Physician _____

Referring Physician _____

MEDICAL HISTORY- Please list past medical problems, illness and diagnoses (include age at time of event)

1. _____
2. _____
3. _____
4. _____

SURGICAL HISTORY- Please list past surgeries (include dates or age at time of surgery and place of surgery)

1. _____
2. _____
3. _____
4. _____

SOCIAL HISTORY

With whom does the child live? (list all in household) _____

Are parents together, separated or divorced? _____

Does your child play any sports? _____ Does your child attend school or daycare? ☐ Yes ☐ No

Does your child or anyone in the home smoke or use tobacco products? ☐ Yes ☐ No
If yes, please explain_____

Are immunizations up to date? ☐ Yes ☐ No Any dietary restrictions/special diet? ☐ Yes ☐ No

ALLERGIES- Please list any allergies and drug reactions.

Allergy (list allergy and reaction)	Drug Reaction (list drug name and reaction)
_____	_____
_____	_____
_____	_____

Today's Date _____

FAMILY HISTORY

☐ No known family health problems ☐ Unknown, patient is adopted/in foster care

Please list health problems of biological mother, biological father and brothers and sisters. _____

_____

Do any of your immediate family members, grandparents, uncles, aunts or cousins have any of the medical problems listed below? Indicate relationship.

☐ Asthma _____ ☐ Birth Defects _____

☐ Bleeding/Clotting Disorder _____ ☐ Blindness/Deafness _____

☐ Brain or Spinal Tumors _____ ☐ Cerebral Palsy _____

☐ Craniosynostosis _____ ☐ Spina Bifida _____

☐ Diabetes _____ ☐ Down's Syndrome _____

☐ Heart Disease _____ ☐ Hyperactivity _____

☐ Liver Disease _____ ☐ Mental Retardation _____

☐ Migraine Headaches _____ ☐ Movement Disorder _____

☐ Neurofibromatosis _____ ☐ Tuberous Sclerosis _____

☐ Seizures/Convulsions _____ ☐ Other _____

DEVELOPMENTAL HISTORY- When did child meet the following developmental milestones? Indicate age in months

Rolled over _____ Pulled to stand _____ Walked holding onto

Tracked with eyes _____ Walked without help _____ Furniture _____

Potty trained _____ Talked in short phrases _____ Walked with walker or

Crawled on hands/knees _____ Army crawled _____ Assisted device _____

Good head control _____ Sat without support _____

Does child require or have special equipment for daily living? (please be specific)

Walker or Crutches _____

Wheelchair _____

Communication devices _____

Braces _____

Other _____

Does child receive physical therapy, occupational therapy, speech therapy, vision therapy or developmental therapy? ☐ Yes ☐ No If yes, please specify _____

MEDICATIONS- include over the counter, vitamins and supplements.

Medication Name	Reason	Dosage	Schedule

PHARMACY

Name: _____ Address: _____

Phone Number: _____

Today's Date _____

REVIEW OF SYSTEMS- If child has any of the following problems or complaints please check.

GENERAL

☐ recent fevers, chills or sweats
☐ significant weight loss or weight gain
☐ change in behavior
☐ tiredness or drowsiness
☐ irritability/crankiness
☐ lack of interest in play
☐ loss of appetite
☐ problems related to sleep

SKIN

☐ rashes or sores
☐ birth marks
☐ changes in skin or hair texture
☐ other problems _____

EYES

☐ vision changes
☐ decreased vision or blurred vision
☐ double vision
☐ lazy eye or eyes not working together
☐ other problems _____

EARS, NOSE, THROAT

☐ hearing loss
☐ ringing in ears or tinnitus
☐ ear infections or drainage from ears
☐ nasal discharge or congestion
☐ difficulty swallowing liquids or solids
☐ drooling
☐ regurgitation through the nose
☐ frequent or worsening gagging
☐ change in the quality or pitch of voice
☐ other problems _____

CARDIO-RESPIRATORY

☐ breathing problems
☐ wheezing
☐ cough
☐ apnea (breathing stops)
☐ chest pain
☐ heart murmur
☐ blueness around mouth

GASTROINTESTINAL

☐ nausea and/or vomiting
☐ tummy pain or discomfort
☐ gastroesophogeal reflux
☐ constipation or diarrhea
☐ loss of or change in bowel control
☐ other problems _____

URINARY

☐ frequent or excessive urination
☐ pain on urination
☐ urgency to urinate
☐ blood in the urine
☐ urinary tract infections
☐ loss of or change in bladder control
☐ other problems _____

MUSCLES AND BONES

☐ pain in neck, back, arms or leg
☐ joint pain or joint swelling
☐ muscle spasms or cramps
☐ excessive tightness or muscles
☐ spasticity
☐ abnormal postures
☐ uncontrolled movements
☐ tremors or tics
☐ scoliosis/curvature of spine
☐ broken bones
☐ other problems

ENDOCRINE

☐ excessive sweating
☐ excessive thirst and urination
☐ excessive hunger
☐ always too cold or too hot
☐ signs of premature sexual development
☐ other problems

HEMATOLOGICAL

☐ frequent or easy bruising
☐ trouble controlling bleeding from a cut
☐ anemia
☐ other problems _____

Form completed by _____ **Relationship to patient** _____

This section to be completed by office staff

Reviewed by initials _____ Date _____ Time _____