Renown CHILDREN'S HOSPITAL
Renown Children's Hospital • 1155 Mill St. • Reno, NV 89502
775-982-KIDS (5437) • BestMedicineNews.org/kids • renown.org/children

Pediatric Neurology Medical History

Patient's name: ________________________________ Date: ___________________
Date of birth: ______________School: __________________________Grade: ________
Pediatrician: ________________________ Pediatrician phone # ___________________

Main Problem and/or Reason for Visit: (BE SPECIFIC)

____
____

Current medications: None ☐ If yes, write the name of each medication:
1.__________________ 2.__________________ 3.__________________4.__________________
5.__________________ 6.__________________ 7.__________________8.__________________

Family Facts:

	Name:	Age:	Occupation:
Mother:	______________________________	___________	__________________________
Father:	______________________________	___________	__________________________

Parents: ☐ **Married** ☐ **Divorced** ☐ **Single**
Incest ☐ **NO** If yes, specify relationship to the patient: ________________________

Name:	Age:	Grade:
Brothers:		
Sisters:		

Any Family Member with any of the following? Please check all that apply.

☐ Convulsions/Epilepsy **If yes, who:** _______________ ☐ Bipolar **If yes, who:** ________________
☐ Learning Disability **If yes, who:** _______________ ☐ Migraines **If yes, who:** ________________
☐ Schizophrenia **If yes, who:** _______________ ☐ Stroke **If yes, who:** ________________
☐ Panic Disorders **If yes, who:** _______________ ☐ Paralysis **If yes, who:** ________________
☐ Heart disease **If yes, who:** _______________

Birth History:

Pregnancy/Birth/Delivery:

☐ Full term ☐ Pre-mature, **how many weeks?** __________ Labor, how long? ___________________
Complications: ☐ No ☐ Yes, **explain:** _________________________ Labor, how long? _______
☐ Vaginal ☐ Caesarian section ☐ Jaundiced at birth
Name of Hospital? ____________________ Name of obstetrician? ____________________
Birth weight? ________ Breathing well at birth? ____________ Days in nursery? ________

Medical History:

Immunizations up to date: ☐ No ☐ Yes
Previous Surgery: ☐ No ☐ Yes, **explain**: ____

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Champions for Children's Health
Children's Miracle Network Hospitals

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Previous Hospitalizations: ☐ No ☐ Yes, provide reason, hospital name, length of stay and outcome.

____

____

Growth and Development:

Milestones: (check approximate time frame)

	0-3 months	4-7 months	8-11 months	12-15 months	16-19 months	20-24 months	25+months
Rolled Over	☐	☐	☐	☐	☐	☐	☐
Sat Up	☐	☐	☐	☐	☐	☐	☐
Stood	☐	☐	☐	☐	☐	☐	☐
Walked	☐	☐	☐	☐	☐	☐	☐
Words	☐	☐	☐	☐	☐	☐	☐
Toiled Trained	☐	☐	☐	☐	☐	☐	☐

Review of Systems:

Do you now or have you had any problems related to the following systems? **Circle Yes or No.**

Constitutional Symptoms

Fever Y N
Chills Y N
Headache Y N
Other

Eyes

Blurred vision Y N
Double vision Y N
Pain Y N
Other

Allergic/Immunologic

Hay Fever Y N
Drug Allergies Y N
Other

Neurological

Tremors Y N
Dizzy spells Y N
Numbness/tingling Y N
Other

Endocrine

Excessive thirst Y N
Too hot/cold Y N
Tired/sluggish Y N
Other

Integumentary

Skin rash Y N
Boils Y N
Persistent itch Y N
Other

Muscoloskeletal

Join pain Y N
Neck pain Y N
Back pain Y N
Other

Ear/Nose/Throat/Mouth

Ear infection Y N
Sore throat Y N
Sinus problem Y N
Other

Genitourinary

Urine retention Y N
Painful urination Y N
Urinary frequency Y N
Other

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Other

Cardiovascular

Chest pain Y N
Varicose veins Y N
High blobd pressure Y N
Other

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other

Psychologic

Are you unhappy with your life?
Y N
Do you feel severely depressed?
Y N
Have you considered suicide?
Y N
Other

Social: Any problems playing or working with others? ☐ No If yes, please explain:

____

____

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