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## Pediatric Neurology

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## QUESTIONNAIRE

Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: Today's Date: MR #: DOB: Age: Name of Person Completing Questionnaire: **Relationship to Patient:** How did you learn about our practice? **Pediatrician**: Address: Telephone: Self-Referral **Referring Physician**: Address: Telephone: Please bring to your appointment any and all reports of previous neurological testing or

## Please bring to your appointment any and all reports of previous neurological testing or consultation, or reports of significant past medical problems. If your child ever had a brain x-ray, CT, or MRI, please borrow the films or obtain a copy of the films and bring them with you to the visit.

CHIEF COMPAINT: (Please describe the reason for your appointment.)

HISTORY OF PRESENT ILLNESS: (Please describe the problem in detail answering the following questions:

What signs or symptoms is your child experiencing?

How long have these symptoms been present?

What part(s) of the body and what functions are being affected?

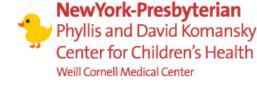
How often do the symptoms occur?

Do symptoms occur at a particular time of day? If so, when?

How severe is the problem?

How long do the symptoms last?

Does anything make the symptoms get better? If so, what?



Has there been prior treatment or surgery for this problem?

# PLEASE DESCRIBE ALL OTHER CURRENT MEDICAL PROBLEMS AND PAST MEDICAL ILLNESSES:

### PLEASE LIST ALL PAST SURGICAL PROCEDURES WITH APPROXIMATE DATES:

#### **CURRENT MEDICATIONS:** (include over the counter, herbal therapies and vitamins).

Medication	Dose	How often
Does the patient have any allergi If yes, please list the medications		] No
<b>BIRTH HISTORY:</b> What was the patient's birth wei Was the patient born prematurely		
If yes, how many weeks prematu		
Were there any problems during	delivery? 🗌 Yes 🗌 No	
If yes, please describe:		
Did the patient have any problem If yes, please describe:	ns in the newborn period (first mor	nth of life)?  Yes No
How long did your child stay in	the hospital after birth?	
<b>DEVELOPMENTAL HISTORY:</b> Have you ever had any worries a	bout abnormal or slow developme	ent in your child? 🗌 Yes 🗌 No
If yes, please describe at what ag development:	ge you first became concerned, and	what symptom(s) made you worry about
Has your child ever lost develop If yes, please describe at what ag	mental skills?	tills were lost:
Has your child ever been part of (for example, cerebral palsy, lear		pmental problem or handicapping condition

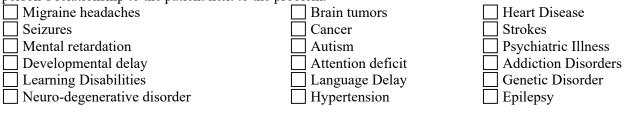
If yes, please describe:

Does your child receive any specialized developmental treatment services or special education program (for example, physical therapy or special classroom placement)? Yes No If yes, please describe:

What is your child's current educational placement (school, grade level)?

## **Family History**

Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.



Is there any other disease/illness that runs in the family?

#### SOCIAL HISTORY

Who lives in the same household with the patient?

Name	Age	Relationship to the patient
	· · ·	
_	_	

Are the parent(s) $\Box$ Single	Separated	] Married	Divorced	Remarried
Any unusual stresses at home or	at school? 🗌 Ye	es 🗌 No		
If yes, please explain.				

	REVIEW OF SYSTEMS Please circle "yes" or "no" for each.							
C	GENERAL	HEAD EARS NOSE MOUTH		CARDIOVASCULAR		GASTROINTESTINAL		
□Yes □No	Altered taste or smell	□Yes □No	Large Head	□Yes □No	Heart defect	□Yes □No	Abdominal pain	
□Yes □No	Change in appetite	□Yes □No	Small head	□Yes □No	Chest pain	□Yes □No	Constipation	
□Yes □No	Feeding problems	□Yes □No	Abnormal Head Shape	□Yes □No	Chest pressure	□Yes □No	Diarrhea	
□Yes □No	Poor weight gain	□Yes □No	Bulging soft spot	□Yes □No	Fainting	□Yes □No	Gastritis	
□Yes □No	Weight loss	□Yes □No	Ringing in ears	□Yes □No	Heart Failure	□Yes □No	Food intolerance	
□Yes □No	Unable to sleep	□Yes □No	Nasal discharge	□Yes □No	Heart Murmur	□Yes □No	Feeding problems	
□Yes □No	Excessive sleepiness	□Yes □No	Sinus problems	□Yes □No	High blood pressure	□Yes □No	Bloody stools	
 □Yes □No	Fatigue	 □Yes □No	Mouth sores	 □Yes □No	Low blood pressure	 □Yes □No	Colic	
	Recurrent Fever		Sore throat		Shortness of breath		Vomiting	
	Recurrent rever		Hearing loss				vornting	
MUSC								
			EYES				RESPIRATORY	
	Spine defects		Blurred vision		Temperature instability		Asthma	
	Neck pain		Double vision		Irregular menses		Bronchitis	
	Joint pain		Glaucoma		Diabetes		Chronic Lung Disease	
□Yes □No	Joint swelling	□Yes □No	Cataracts	□Yes □No	Early or late puberty	□Yes □No	Pneumonia	
	Back or neck pain	□Yes □No	Eye pain	□Yes □No	Thyroid problems	□Yes □No □Yes □No	Tuberculosis	
□Yes □No	Muscle pain						Chronic cough	
	SKIN/HAIR		URINARY		BLOOD/LYMPH		IMMUNOLOGIC/ALLERGY	
□Yes □No	Birth marks	□Yes □No	Increased frequency	□Yes □No	Easy bleeding	□Yes □No	Immune deficiency	
□Yes □No	Skin rash	□Yes □No	Increased urgency	□Yes □No	Easy bruising	□Yes □No	Frequent infections	
□Yes □No	Brittle hair	□Yes □No	Delayed or Regressed toilet training	□Yes □No	Frequent nose bleeds	□Yes □No	Severe infections	
□Yes □No	Easy scarring	□Yes □No	Urinary Infections	□Yes □No	Swollen lymph nodes	□Yes □No	Poor wound healing	
	IOR/PSYCHIATRIC			NEUROLO				
□Yes □No	Anxiety	□Yes □No	Difficulty Concentrating	□Yes □No	Clumsiness	□Yes □No	Choking	
□Yes □No	Depression	□Yes □No	Vertigo	□Yes □No	Facial numbness	□Yes □No	Difficulty chewing	
□Yes □No	Panic attacks	□Yes □No	Dizziness	□Yes □No	Numbness (arms)	□Yes □No	Difficulty swallowing	
□Yes □No	Trouble concentrating	□Yes □No	Headache	□Yes □No	Numbness (legs)	□Yes □No	Difficulty tasting	
□Yes □No	Hallucinations	□Yes □No	Lethargy	□Yes □No	Poor balance	□Yes □No	Difficulty smelling	
□Yes □No	Suicidal thoughts	□Yes □No	Memory problems	□Yes □No	Poor coordination	□Yes □No	Drooling	
□Yes □No	Confusion	□Yes □No	Convulsions	□Yes □No	Speech difficulty	□Yes □No	Hoarseness	
□Yes □No	Personality Change	□Yes □No	Seizures	□Yes □No	Stiffness	□Yes □No	Incontinence- bowel	
□Yes □No	Temper tantrums	□Yes □No	Syncope	□Yes □No	Trouble walking	□Yes □No	Incontinence- bladder	
□Yes □No	Withdrawn behavior	□Yes □No	Sleep problems	□Yes □No	Weakness (arms)	□Yes □No	Pain	
□Yes □No	Aggressive behavior	□Yes □No	Blurred vision	□Yes □No	Weakness (legs)	□Yes □No	Abnormal movements	
□Yes □No	Inattention	□Yes □No	Double vision	□Yes □No	Tremor			
□Yes □No	Hyperactive							
□Yes □No	Impulsive	describe).						

Other Symptoms (please describe):

Х

Parent/Guardian/Patient Signature

Х

Physician Signature

Date

Date

Please return this questionnaire to <u>pedsneurotele@med.cornell.edu</u> prior to the doctor's visit.

## **Race and Ethnicity Information**

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

## **Primary Language**



## Race

American Indian or Alaska Native Black or African American White Declined

Asian

Native Hawaiian or Other Pacific Island

Other Combination Not Described

## Ethnicity

Hispanic or Latino or Spanish Origin Not Hispanic or Latino or Spanish Origin Declined

## **Pharmacy Information**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

New

Date:

Patient Name:

NYH #:

## <u>PRIMARY</u>

Pharmacy Name:

Address:

Phone Number:

Fax Number:

**SECONDARY** (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: