Providence Pediatric Subspecialties Clinic
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Neuroscience Patient Medical History

Patient Name: _____ **Preferred Name:** _____ **DOB:** _____

Name of Person Completing Form: _____ **Relationship:** _____

Primary Care Provider: _____

List All other health care providers who currently see your child: _____

_____

Reason for today's visit: _____

ALLERGIES: Does the patient have any allergies to medications, foods, or other substances? ☐ Yes ☐ No
If yes, please list all allergies and reactions (including rash, hives, throat swelling, anaphylaxis)

Allergy	Reaction	Allergy	Reaction

MEDICATIONS: Does your child take any medications? ☐Yes ☐ No
If yes, please list ALL current medications, including over the counter, vitamins/herbal supplements.

Medication Name	Dose	Times a Day	Medication Name	Dose	Times a Day
Preferred Pharmacy Name:			Location:		

Please list any surgeries/procedures and hospitalizations your child has had. ☐ Yes ☐ No ☐ None

Hospitalization or procedures/surgeries	Age	Hospitalization or procedures/surgeries	Age

MEDICAL HISTORY

Has your child ever experienced a significant fall, loss of consciousness or had a serious accident? ☐ Yes ☐ No
If yes, please explain with date(s):

Does your child have any significant illness or health problems? ☐ Yes ☐ No *If yes, please describe:*

Are your child's immunizations up to date? ☐ Yes ☐ No

Test	Date	Where was the test done	Test	Date	Where was the test done
EEG			Labs		
MRI			Vision		
CT Scan			Hearing		

Family Medical History: List any relative with the following problems:

Migraine Headaches:	Mental Illness:
Seizures/Epilepsy:	Tics/Unusual Movements:
Birth Defects:	Intellectual/Developmental Disability:
Learning Problems:	Alcohol/Drug Abuse:

PREGNANCY HISTORY

Were there any problems in the pregnancy? Please check all that apply. ☐ Yes ☐ No ☐ Unknown

☐ Bleeding	☐ Hospitalization	☐ Surgery
☐ Diabetes	☐ Premature Labor	☐ Infection:
☐ High blood pressure	☐ Pre-eclampsia	☐ Other:

Method of conception: ☐ Natural ☐ IVF ☐ Surrogate ☐ Other: (please specify)

Were any medications or drugs used in the pregnancy? Please check all that apply. ☐ Yes ☐ No ☐ Unknown

☐ Alcohol (amount):	☐ Smoking (amount):
☐ Prescription medication (please specify):	☐ Other drugs (please specify):
☐ Prenatal Vitamins	☐ Folic Acid

Other:

Were any tests or procedures done in the pregnancy? Please check all that apply. ☐ Yes ☐ No ☐ Unknown

☐ Amniocentesis, results:	☐ Maternal serum screening, results:
☐ Carrier screening (please specify):	☐ Noninvasive Prenatal Testing (NIPT), results:
☐ Chorionic villi sampling (CVS), results:	☐ Ultrasound, results:
☐ Fetal MRI, results:	☐ Other:

Mother's age at delivery:	Length of pregnancy (weeks):
Labor: ☐ Spontaneous ☐ Induced, reason:	**Delivery:** ☐ Vaginal ☐ C-section

BIRTH HISTORY

Weight:	Length:	Apgar Score if known:

Did your child spend time in the NICU (Neonatal intensive care unit)? ☐ Yes ☐ No ☐ Unknown

Please explain:

Were there any medical concerns when the child was a newborn? Check all that apply. ☐Yes ☐ No ☐Unknown

☐ Breathing problems	☐ Jaundice	☐ Seizures
☐ Feeding Problems	☐ Low muscle tone	☐ Medications
☐ Birth defect (please specify):	☐ Other Problems:	

DEVELOPMENTAL HISTORY

Were you ever concern about your child's development? ☐ Yes ☐ No *If yes, at what age?*

Please give the age when your child did the following:

Rolled over:	Sat alone:	Crawled:	Walked:
Coo:	Laughed:	Smile:	Potty trained:
Said "mama" or "dada":	Put two words together:	Transferred toy from one hand to the other:	

Did your child have a hand preference before 12 months of age? ☐ Yes ☐ No

Which hand does your child use know? ☐ Left ☐ Right ☐ Both equally

Is your child in a special education program right now? ☐ Yes ☐ No

☐ Early Intervention ☐ Inclusion Program ☐ Special Education classroom ☐ 504 ☐ IEP

☐ Other:

Name of School: **Grade:**

Do you have any concerns about your child's behavior? ☐ Yes ☐ No

☐ Short attention span	☐ Anxiety	☐ Depression	☐ Hurts self
☐ Hurts others	☐ Atypical eating habits	☐ Trouble with the law	☐ Autism Spectrum Disorder

Other Problems:

REVIEW OF SYSTEMS

In the PAST 6 MONTHS -check (√) the box if the patient has had any of the problems listed below:

	GENERAL		**GASTROINTESTINAL**		Muscle Weakness
	Decreased Activity / Energy		Abdominal Pain		**NEUROLOGICAL/PSYCHOLOGIC**
	Recurrent Unexplained Fever		Bloody Stool		ADD/ADHD
	Weight Gain– Abnormal		Constipation		Anxiety
	Weight Loss		Diarrhea		Autism
	Poor Appetite		Feeding Issues		Behavioral Problems
	HEENT		Jaundice (Yellow Skin or Eyes)		Depression
	Difficulty Swallowing		Liver Disease		Developmental Delays
	Chronic Ear Infections		Spitting Up / Reflux		Dizzy / Lightheadedness
	Chronic Nasal Congestion		Vomiting		Frequent or Recurring Headaches
	Chronic Sore Throat		Vomiting Blood		Mood Swings
	Hearing Loss		**ENDOCRINE**		Night Terrors
	Mouth Sores		Diabetes		School Problems
	Runny Nose		Excessive Thirst		Seizures
	Vision Problems Other Than Glasses		Excessive Urination		Significant Head Injury
	Watery Eyes		Growth Problems		Sleeping Difficulties
	RESPIRATORY		Thyroid Disease		**HEMATOLOGIC/LYMPH**
	Asthma		**GENTOURINARY**		Anemia
	Chronic/Recurrent Cough		Blood in Urine		Easy to Bleed
	Pneumonia / Bronchitis		Bed Wetting		Easy to Bruise
	Wheezing		Painful Urination		Swollen Lymph Nodes
	CARDIOVASCULAR		Urinary Tract Infections		**SKIN**
	Blood Pressure Issues		Kidney Disease		Acne
	Chest Pain		Menstrual Problems		Eczema
	Fainting		**MUSULOSKELETAL**		Pale Looking Skin
	Heart Disease		Joint Pain		Rash
	Irregular Heartbeat		Joint Swelling		**OTHER**
	Murmur		Muscle Pain		Anesthesia Complications

Please list any other chronic medical conditions / diagnosis your child may have: