

**Josephson-Wallack-Munshower Neurology
Child Neurologic Health History Data Sheet**

New Visit

Date: _____

Child's Name: _____

Age: _____

Date of Birth _____

Gender: M F

Is your child right or left handed: R L

Who is your child's Doctor? _____

Who referred you to Dr. Ridel? _____

Reason for Neurological Evaluation: _____

Medical History:

Any previous health problems: None _____

Immunizations up to date: Yes No

Previous Hospitalizations: None _____

Operations: None _____

Serious Injuries/Broken Bones: None _____

History of Febrile Seizures: Yes No

History of brain infections (meningitis, encephalitis): Yes No

History of traumatic loss of consciousness: Yes No

Developmental History:

At what age did the patient achieve these milestones:

Gross Motor:

Rolls over _____

Sits alone _____

Walks _____

Fine Motor:

Finger feeds _____

Scribbles _____

Expressive Language:

Babbles _____

Says "mama" or "dada" _____

Says two words together _____

At what age do think your child is functioning?: _____

Prenatal/Birth History:

How many previous pregnancies: _____ Miscarriages/Abortions: _____

Mother's age at patient's birth: _____ Father's age at patient's birth: _____

Was the baby full term: Y N If No, how early: _____ weeks Birth weight: _____ lbs _____ oz

Describe any difficulties during pregnancy with patient (bleeding, high blood pressure, infections, etc): _____

List medications taken during pregnancy with patient: _____

Labor: Spontaneous Induced Length of Labor: _____ Hours

Delivery: Vaginal C-Section Forceps: Yes No

Describe any difficulties during labor: _____

Birth/Neonatal History:

Apgar Score: _____ at one minute; _____ at five minutes. Did the baby require oxygen: Y N

Describe any special medical problems as a newborn: None _____

Medications:

	Name of the medicine	Dose and frequency/time of the day
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		

Allergies:

Does the patient have any allergies to medications? None _____

Family History:

List members of the patient's family with medical or neurological problems (such as stroke, heart disease, migraine, mental retardation, learning disabilities, seizures, childhood death, etc.) _____

Social History:

List the name and age of all persons living in the patient's home: _____

Parents' Occupation: _____

Educational History:

Current Grade: _____ School: _____

Describe any special help needed or specific problems noted in school: _____

Review of Systems:

Check below areas of concern the patient and/or you currently have:

Concerns	No Concerns	Comments
		Headaches _____
		Sleep problems _____
		Excessive daytime sleepiness _____
		Visual Changes _____
		Hearing Problems _____
		Dizziness _____
		Fever _____
		Heart problems _____
		Upper Respiratory Symptoms _____
		Nausea or vomiting _____
		Diarrhea or constipation _____
		Urinary difficulties _____
		Joint or muscle pain _____
		Rash or skin problems _____
		Behavioral problems _____
		Learning problems _____
		Other _____

I have answered these questions to the best of my knowledge.

Patient/Parent/Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

Keith R. Ridel, M.D.: _____