Patient Sticker Here

Children's Hospital Colorado

www.childrenscolorado.org

NEUROLOGY DEPARTMENT FOLLOW-UP PATIENT HISTORY FORM

GENERAL INFORMATION

Name of Child/Patient _____ Child's Birthdate _____

Name of Person Filling out form _____ Relationship _____

What is the main problem or issue that you want to talk about during your neurology visit today?

_____

_____

MEDICAL HISTORY

Any change(s) to current list of medicines? ☐ No ☐ Yes Describe if yes _____

Any reactions or side effects of medicines? ☐ No ☐ Yes Describe if yes_____

Does your child have any problems with? (Please answer below)

	No	Yes	Briefly describe		No	Yes	Briefly describe
Growth (changes ht or wt)				Stomach			
Sleep				Bladder/bowel			
Mood or behavioral issues				Bones/muscles			
Skin				Blood			
Eyes				Hormone system			
Ears/Nose/Throat				Nervous system			
Heart				Learning			
Lungs/breathing				Other			

In the past 6 months, has your child had any lab tests, procedures or scans? ☐ No ☐ Yes

Describe if yes _____

In the past 6 months, has your child had any emergency room (ER) visits? ☐ No ☐ Yes

Describe if yes _____

FAMILY

Have there been any changes in who your child lives with? ☐ No ☐ Yes Describe if yes _____

Do you know of any new information about the health of family members that may have similar or related problems to your child's concerns? ☐ No ☐ Yes Describe if yes _____

IN SCHOOL AND AT HOME

Grade in School: _____ **Name of school**: _____

How are your child's grades in school? ☐Excellent ☐Good ☐Average ☐Below Average ☐Failing

Does your child have any new learning concerns or changes in their grades? ☐ No ☐ Yes

Have there been any changes in your child's IEP/504? ☐ No ☐ Yes ☐ Doesn't Apply

What activities or sports is your child involved in: _____