Patient Sticker Here

Children's Hospital Colorado

www.childrenscolorado.org

NEUROLOGY DEPARTMENT NEW PATIENT HISTORY FORM

Name of Child/Patient ________________________________ Child's Birthdate ___________________________

Name of Person Filling out form _________________________ Relationship ______________________________

What is the main concern/worry today? ____

What questions do you want answered today?

1. ____

2. ____

3. ____

Primary Care Provider (pediatrician/family practice) ____

Other doctors involved in your child's/patients care ____

CURRENT MEDICATIONS

(Please also include any supplements, herbal products or vitamins)

Medication	Dose	How often	Date started taking	Side Effects

PAST HEALTH HISTORY

Hospitalizations ____

Surgeries ____

Serious Accidents/head injury ____

Medications taken in the past (name, dose, when used and side effects):

_________________________________ _____________________________________

_________________________________ _____________________________________

_________________________________ _____________________________________

Are child's immunizations (shots) up to date? Yes No

Flu shot? Yes No

Please turn over, more on back

Allergies

Medication ________________ Environmental______________________ Food __________________________

Testing

Include type of test, date and results:

Test type	Date	Results	Test type	Date	Results	Test type	Date	results
EEG			MRI			CT/CAT scan		
Labs			Vision			Hearing		

DOES YOUR CHILD HAVE ANY PROBLEMS WITH?

	No	Yes	Describe if yes		No	Yes	Describe if yes
Growth (changes in height and weight)				Stomach			
Sleep				Bladder/bowel			
Mental health/mood issues/behavioral issues				Bones/muscles			
Skin				Blood			
Eyes				Hormone system			
Ears/Nose/Throat				Nervous system			
Heart				Learning			
Lungs				Other			

DEVELOPMENT

What hand does your child write/eat with? _______

Did your child favor one hand before 12 months of age Yes No

If normal development check here and do not fill out ages below_____

If development delayed; tell us how old your child was when they did the following:

AGE
____Rolled over
____Sat alone
____Crawled
____Walked

AGE
____Coo
____Laughed
____Said 'mama' or 'dada' _
____Put two words together

AGE
____Transferred toy one hand to the other
____Fed self cracker
____Potty trained by day
____Potty trained by night

Therapy	No	Yes	When/where
Physical			
Occupational			
Speech			

SCHOOL

Grade in School___________ Name of School ___________________________

Regular Classes	Yes	No
Special Classes	Yes	No
Special Classes in past	Yes	No
IEP/504 modifications	Yes	No

School performance: Excellent____ Good____ Average____ Below Average ____ Failing ____

Activities/Sports____

PREGNANCY HISTORY FOR MOTHER OF CHILD

Age of Mother at delivery ____________

Number of Pregnancies before this ______

During the pregnancy did any of these happen?

	No	Yes	If yes describe
Prenatal care- starting what week			
Prenatal testing (blood/CVS/AFP)			
Infection/illness/flu			
Bleeding			
Radiologic Scans/Xray/ultrasounds			
Preterm labor			
High blood pressure			
High blood sugar/Diabetes			
Medications (prescription/over the counter OTC)			
Alcohol/Drugs/Tobacco			

LABOR, DELIVERY AND NEWBORN HISTORY

Full term _________ **OR** Preterm (please include number of weeks early) ___________
Vaginal __________ **OR** C section (please include why) _________________________
Birth Weight ___________

Were there any issues after delivery or within the 1st week of life?

	No	Yes	If Yes describe
Breathing problems/Oxygen use			
Jaundice (eyes and skin yellow)			
Seizures			
Feeding issues			
Other issues			

How long did the newborn spend in the hospital? (Days)_______________

Please turn over, more on back

FAMILY MEDICAL HISTORY

List any biologic relative of patient/child (parents, grandparents, siblings) with the following:

	Relative's relationship and name
Seizures/Epilepsy	
Tics/movements disorder/tremor (shaking)	
Headaches/migraine	
Motion sickness	
Fainting/syncope	
Stroke/clotting disorder/bleeding	
Heart disorder/cardiac	
Learning problems/ADHD/dyslexia	
Developmental delay	
Birth defect/genetic syndrome	
Autoimmune (thyroid, diabetes, MS)	
Mood issues/mental health issues	
Drug abuse	
Other	

SOCIAL HISTORY

Child lives with ☐ Biologic Parents ☐ One Parent ☐ Parent and Step Parent
☐ Legal Guardian ☐ Adoptive Parents ☐ Other: ________

Parents Name Age Job

____

____

Brothers/sisters (name and age):

Name Age

____

____

____

____