Follow-up Interim Medical History

Please fill out this form, and indicate any changes since the last visit in neurology.

Child's name: DOB:

REVIEW OF SYSTEMS

Please indicate if your child has had any of the following symptoms since the last visit:

Symptoms (Circle any that are present)	No	Yes	Details
Recent fever, weight loss, weight gain, fatigue			
Abnormal head shape, head growing too slowly, or enlarging head size; recent head trauma resulting in headache, vomiting, dizziness, or loss of consciousness			
Eye problems such as double or blurred vision, blindness, cataracts, or unusual visual sensations			
Ear, nose or throat problems such as difficulty with hearing, persistent nasal congestion or discharge, trouble with swallowing, sore throat, mouth ulcers			
Stiffness of neck, lumps on neck, restricted range of motion, head tilt or pain in neck			
Difficulty with breathing, shortness of breath, wheezing abnormal chest movements, abnormal shape of chest, winging of scapula			
Chest pains, heart palpitations, racing heart rate, fainting spells, heart murmur			
Stomach pains, persistent nausea, vomiting, diarrhea, constipation, abdominal cramping			
Difficulty with urination or bowel movements, frequent urination, early or late puberty			

Symptoms (Circle any that are present)	No	Yes	Details
Pain, swelling or redness of joints, joint stiffness, back pain, or pain in any extremity			
Rash, new skin changes in color or new light or dark spots, acne			
Sleep issues such as falling asleep, staying asleep, excessive daytime sleepiness, significant snoring			
Headaches, dizziness, numbness, tingling, weakness, abnormal movements, unexplained loss of consciousness, loss or speech, loss of motor skills, difficulty walking, complaints of dizziness, regression in behavior			
Behavioral difficulties, mood swings, excessive sadness, anger management challenges, worries excessively, known psychiatric diagnosis			
Difficulties in school such as delays in learning, difficulty concentrating, not able to keep up with peers in class			
Difficulty with social skills, having difficulty reading social cues, challenges interacting with peers his/her age, inappropriate play and activities for age, interests that are excessive and perseverative			
Known endocrine issues such as thyroid problems, diabetes, etc.			
Excessively easy bruising or bleeding, clotting problems, anemia, blood problems, swollen glands			
Environmental or seasonal allergies, hay fever, anaphylaxis, immune deficiency			

PLEASE LIST CURRENT MEDICATIONS:

Medication	Dosage form	Dose	Frequency

ALLERGIES:

Any new allergies since the last visit? No Yes If yes, please list below:

Medications:

Medication	Reaction

Environmental:

Allergen	Reaction

MEDICAL CHANGES

Have there been any changes in your child's current neurological and/or medical condition since his/her last visit?

No Yes

If yes, please explain:

Signature: Date: