Stanford Children's Health

Medical History Form

This information will become part of the patient's permanent records, and as with all information, will remain confidential. Please fill out as accurately as possible.

Child's name: DOB:

REVIEW OF SYSTEMS

Please indicate if your child has had any of the following symptoms over the past 3-6 months, in addition to the concerns that resulted in seeking a neurology consultation:

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			

PREGNANCY, LABOR & DELIVERY:

Please note--it is not necessary to fill out this section if your child or you are being seen for headaches. You may proceed to "PAST MEDICAL HISTORY."

Were fertility treatments used to get pregnant? No Yes
Were there any difficulties with the pregnancy? No Yes

If yes, please explain:

Was your child born: on time early late Gestational age: weeks

Were there any difficulties with the labor or delivery: No Yes

If yes, please explain:

PREGNANCY, LABOR & DELIVERY, CONTINUED:

How old was the mother when the child was born?

What number pregnancy? What number live delivery?

At what hospital was the child born?

How much did the child weigh? lbs .oz Do not recall

Do you know the Apgar scores? No Yes If yes, at: 1 minute: 5 minutes: 10 minutes:

DEVELOPMENTAL HX:

Please note---it is not necessary to fill out this section if your child or you are being seen for headaches. You may proceed to "PAST MEDICAL HISTORY."

How old was your child when he/she did the following:

- Reached for objects *(typical 3 months):*
- Rolled over *(typical 3-4 months):*
- Sat independently *(typical 6-7 months):*
- Crawled on all 4 arms and legs *(typical by 12 months):*
- Pulled up to a stand and cruising:
- Walked independently *(typical by 12-18 months):*
- Babbled with consonants *(typical by 6-8 months):*
- Waved bye-bye *(typical by 7-8 months):*
- First words *(typical by 12-14 months):*
- Vocabulary of 50 words and starting to put 2 words together in sentences *(typical 24 months):*

PAST MEDICAL HISTORY:

Please describe any past medical problems your child may have had. Where possible, give dates of illnesses/surgeries:

Hospitalizations and/or surgeries:

Chronic illnesses or traumas:

PLEASE LIST CURRENT MEDICATIONS:

Medication	Dosage form	Dose	Frequency

ALLERGIES:

Medications:

Medication	Reaction

Environmental:

Allergen	Reaction

PAST FAMILY HISTORY:

Please describe any medical problems that exist or have existed in close family members. In particular, please note any history of seizures, epilepsy, migraine headaches, or any other nerve or muscle problems. List the problem and affected individual (s) if known:

Family Member	Known Medical Problems

SOCIAL HISTORY:

Who does the child currently reside with? (Please include age and sex of siblings)

What is the occupation of the father?

What is the occupation of the mother?

What grade is the child in and what school does the child attend?

How does he/she perform in school?

What are the child's activities and/or interests?

Is there any litigation pending on your child's medical and/or neurological concerns? No Yes

If yes, please explain:

Are there any other concerns or questions that you would like to address in your initial appointment?

Signature: Date: