UNIVERSITY OF VIRGINIA HEALTH SYSTEM

0300004

PLACE LABEL HERE.

IF LABEL NOT AVAILABLE, WRITE IN PT NAME & MR#

DEPARTMENT OF NEUROLOGICAL SURGERY MEDICAL HISTORY FORM – PEDIATRIC PATIENTS

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR SCHEDULED APPOINTMENT AS WELL AS ALL YOUR MEDICATIONS AND ANY PRIOR MEDICAL RECORDS OR X-RAYS

Please assist in obtaining the most accurate information regarding your medical history by completing the information below. If you have already completed this form for our department, please disregard. Your assistance is greatly appreciated.

GENERAL INFORMATION: Date: _____

Name _____
LAST FIRST MIDDLE INITIAL

Home Address _____

_____
(CITY) (STATE) (ZIP CODE)

Home Phone ( ) _____ Work Phone ( ) _____

Date of Birth:_____ Gender (check one): ☐Male ☐Female Are you: ☐Left-handed ☐Right-handed ☐Ambidextrous

1. Please give the name, address, and phone # of your pediatrician / family Dr. and any referring Dr.'s you would like information sent to: _____

_____

2. What is the main reason for your visit today? _____

3. Did you bring medical records, slides, and/or x-rays with you today? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS: Please describe the symptoms of your medical problem.

Location and Severity of Problem: _____

How long have you had the symptoms? _____ When do you have the symptoms? _____

What makes the symptoms better or worse? _____

MEDICAL HISTORY:

1. Term Birth? Yes____ No____ If not, birth at _____ weeks gestation. Method of delivery: Vaginal _____ C-Section _____

2. List any medical conditions you have:

MEDICAL CONDITIONS

Condition	When Diagnosed?	Condition Currently Under Treatment

3. Have you ever been hospitalized or had surgery? ☐ No ☐ Yes If yes, please list all previous surgeries and hospitalizations below (include dates and hospitals when possible).

HOSPITALIZATIONS

Date of Hospitalization	Type of Surgery	Reason for Surgery

4. **DEVELOPMENTAL HISTORY: (circle all that apply)**

Able to hold head up	Able to sit up unassisted	Able to imitate speech/sounds	Able to speak in sentences
Able to follow object with eyes	Able to crawl	Able to walk	Able to use fork and spoon
Able to grasp toy	Able to feed self	Able to speak simple words	Able to dress self
			Able to broad jump

5. **ARE YOU CURRENTLY UNDERGOING:**

Physical Therapy ☐ No ☐ Yes Occupational Therapy ☐ No ☐ Yes Speech Therapy ☐ No ☐ Yes

6. Do you take any medications? ☐ No ☐ Yes If yes, please list below:

CURRENT MEDICATIONS

Name/Dose/Route of Medication	Date Started Medication	How Often Is It Taken?	Reason for Taking Medication

7. Do you have any known drug allergies? ☐ No ☐ Yes If yes, please list them below:

KNOWN ALLERGIES

Name of Medication	Reaction to Medication

FAMILY HISTORY: (Please list any illnesses that run in your family, including heart disease, diabetes, seizures, or cancer)

_____

_____

SOCIAL HISTORY: (Please circle the correct answer)

- Education: PRESCHOOL GRADE SCHOOL MIDDLE SCHOOL HIGH SCHOOL COLLEGE

Who do you live with? _____

REVIEW OF SYSTEMS: (Please check all that describe your symptoms)

Constitutional
- ☐ Fever
- ☐ Night sweats
- ☐ Weight loss

Cardiovascular
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Irregular heart beat

Respiratory
- ☐ Chronic cough / Coughing blood
- ☐ Bronchitis
- ☐ Asthma

Gastro-Intestinal
- ☐ Blood in stool/Dark colored stool
- ☐ Nausea/Vomiting
- ☐ Abdominal Pain
- ☐ Incontinence / Constipation / Diarrhea

Genito-Urinary
- ☐ Burning with Urination
- ☐ Difficulty starting / ending urine stream
- ☐ Poor bladder control of incontinence
- ☐ Loss of sensation of genitals
- ☐ Inability to obtain, maintain erection

Endocrine
- ☐ Nipple discharge
- ☐ Dry skin
- ☐ Loss or gain of body hair
- ☐ Anxiety
- ☐ Weight loss or gain
- ☐ Excessive thirst

Hematologic
- ☐ Easy bruising
- ☐ Nose bleeds
- ☐ History of excessive bleeding with previous surgeries

Neurological
- ☐ Change in vision (blurry, double)
- ☐ Loss of hearing or ringing in ears
- ☐ Facial numbness
- ☐ Facial weakness
- ☐ Decreased sense of smell or taste
- ☐ Difficulty swallowing
- ☐ Slurred speech
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures

Musculoskeletal
- ☐ Neck pain
- ☐ Arm pain / numbness / weakness
- ☐ Loss of arm / hand coordination
- ☐ Back pain
- ☐ Leg pain / numbness

Completed by: _____
Patient / Parent / Guardian Signature

Reviewed by: _____ PIC # _____ Title _____ Date_____