NEUROLOGY GROUP OF BERGEN COUNTY, P.A.
PEDIATRIC NEUROLOGY

NAME _____DATE _____

Grade _____ Age _____

CHIEF COMPLAINT:

_____

_____

_____

_____

How long have the symptoms been present? _____

Is there anything that makes the symptoms worse? _____

better? _____

NEUROLOGICAL SYMPTOMS:

Headache	Yes / No	Tics/Habits	Yes / No
Fainting spells	Yes / No	Dizziness	Yes / No
Seizures	Yes / No	Numbness	Yes / No
Severe head injury	Yes / No	Memory difficulty	Yes / No
Sudden visual loss	Yes / No	Depression	Yes / No
Double vision	Yes / No	Neck Pain	Yes / No
Low back pain	Yes / No		

Have you ever consulted a neurologist before: YES / NO

Are you right-handed or left-handed? RIGHT / LEFT

PAST MEDICAL HISTORY:

High blood pressure	Yes / No	Diabetes	Yes / No
Heart disease	Yes / No	Lyme Disease	Yes / No
Asthma	Yes / No	Thyroid disease	Yes / No
Environmental Allergies	Yes / No		

DEVELOPMENTAL HISTORY:

Born: Full term premature _____weeks

Vaginal delivery C-section ? Emergency

Walked age _____ First words age _____

SURGICAL HISTORY:

Ear Tubes - _____

Tonsillectomy - _____

Adenoidectomy - _____

Other - _____

HOSPITALIZATIONS:

_____

_____

_____

(PLEASE COMPLETE OTHER SIDE)

MEDICATIONS: (include dosage and frequency)

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

ALLERGIES TO MEDICATIONS:

None Penicillin Sulfa drugs X-ray dye
Other: _____

SOCIAL HISTORY:

Smoking: No / Yes Amount? _____
Alcohol: None Occasional Daily Amount? _____
Living arrangements: Both Parents Mother Father Other
School grade: _____

FAMILY HISTORY: (circle any that apply)

Migraine	Seizures	Brain Tumor	Febrile Seizures
Parkinson's	Alzheimer's	Stroke	ADHD
Nerve disease	Muscle diseases	Multiple Sclerosis	Learning disabilities
Mental retardation	Depression	Mental illness	Tics
Hypertension	Heart disease	Diabetes	

Siblings? # _____

REVIEW OF SYSTEMS: (circle any that apply)

CONSTITUTIONAL: none fever weight change extreme fatigue _____
SKIN: none rash birthmarks (<5) _____
EYES: none pain in eyes wear glasses/contacts _____
ENT: none ringing in ears sinus infections
_____ grind teeth difficulty swallowing pain with swallowing ____
CARDIOVASCULAR: none chest pain palpitations irregular beat murmur _____
RESPIRATORY: none shortness of breath chronic cough wheezing _____
GASTROINTESTINAL: none nausea vomiting constipation abdominal pain __ _____
GENITO-URINARY: none incontinence _____
HEMATOLOGY: none bleeding tendency easy bruising _____
GYNECOLOGY: none Menstrual cycle regular _____
PSYCHIATRIC: none depression anxiety hallucinations insomnia _____
MUSCULOSKELETAL: none muscle pain joint pain joint swelling stiffness _____

Patient's Signature _____ Reviewed by MD _____
initials