MICHIGAN STATE UNIVERSITY HEALTHTEAM

Print Form

MICHIGAN STATE UNIVERSITY
DEPARTMENT OF NEUROLOGY AND OPHTHALMOLOGY

PEDIATRIC NEUROLOGY SERVICES PATIENT QUESTIONNAIRE

Douglas Postels, M.D. I. Zachary Dyme, M.D.

Patient Name: _____ Address: _____

City: _____ State: _____ ZIP: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email Address: _____

Date of Birth: _____ Place of Birth: _____

Age: _____ (years) _____ (months) Sex: _____ ☐ Right Handed ☐ Left Handed ☐ Ambidextrous

Mother: _____ Age: _____ Father: _____ Age: _____

Highest grade in school: _____ Occupation: _____ Highest grade in school: _____ Occupation: _____

Check one: ☐ Biological Parent ☐ Adoptive Parent Check one: ☐ Biological Parent ☐ Adoptive Parent

Past and Present Health: Past and Present Health:

SIBLING NAME	AGE	RELATIONSHIP TO PATIENT	PAST AND PRESENT HEALTH	GRADE IN SCHOOL

Referring Physician or Agency: _____ Primary Care Physician or Pediatrician: _____

Address: _____ Address: _____

City: _____ State: _____ ZIP: _____ City: _____ State: _____ ZIP: _____

Phone Number: _____ Phone Number: _____

Patient Name:

Please write a brief account of the child's illness or complaint, beginning with the initial complaint, the age at the time it began, a description of the complaint, and the course of the complaint.

Please **LIST ALL MEDICATIONS** the child has has taken in the ***past.*** (**Attach a separate list if necessary or bring list with you to the appointment)**

MEDICATION	DOSE/FREQUENCY	YEARS/MONTHS TAKEN	HOW DID THIS EFFECT THE COURSE OF THE COMPLAINT?

PREVIOUS TESTING (Please list any diagnostic tests done. We would like to see the **CD's** from all of these tests)

Test	When	Where	Results

Patient Name:

FAMILY MEDICAL HISTORY (Please indicate below if any immediate family members have the illness. List the family members and their age at onset of condition)

◯ ADHD		◯ Cerebral Palsy		◯ Learning or reading difficulties	
◯ Alcoholism		◯ Chiari malformation		◯ Mental retardation	
◯ Aneurysm		◯ Chromosome abnormality		◯ Muscle or nerve disease	
◯ Asthma		◯ Convulsions, Epilepsy, Seizures		◯ Stroke	
◯ Autism		◯ Depression/Anxiety		◯ Thyroid disease	
◯ Bipolar or Schizophrenia		◯ Diabetes		◯ Tics	
◯ Bleeding disorder		◯ Gait abnormality		◯ Tourette Syndrome	
◯ Brain Tumor		◯ Headaches/ Migraines		◯ Tremors	
◯ Cancer (type)		◯ High blood pressure		◯ Tuberculosis	

PREGNANCY AND BIRTH HISTORY: Were there any serious problems with the pregnancy or birth of your child?

If yes, please complete below. If no, please skip ahead to ***developmental landmarks of child***. ◯ NO ◯ YES

Duration of pregnancy:_____ (months) Tobacco, alcohol, or illicit drug use during pregnancy? ◯ NO ◯ YES Which? _____

Was labor: ☐ Spontaneous ☐ Induced ☐ Forceps ☐ C-section ***Born:*** ☐ Head first ☐ Feet first

Difficulties (please explain): _____

Birth weight: _____ lbs. _____ oz. OR _____ kg. Did the baby have any trouble starting to breathe? ◯ NO ◯ YES

Did the baby have any trouble while in the hospital? ◯ NO ◯ YES

If yes, please describe: _____

Age of baby at time of hospital discharge: _____ Was the child adopted? ◯ NO ◯ YES

DEVELOPMENTAL LANDMARKS OF CHILD (Please list ***dates***): Were the developmental milestones normal? ◯ NO ◯ YES

If no, please complete below ***(list dates next to each development landmark)***. If yes, please skip ahead to ***school progress.***

Smiled:		Went from laying to sitting on own:		Spoke single words:	
Made Random Sounds:		Said repetitive syllables (ma-ma, da-da):		Spoke short sentences:	
First sat alone when placed:		Walked alone:		Potty trained:	
Able to ride a tricycle:		Able to ride a bicycle:			

Patient Name:

SCHOOL PROGRESS (if child is not in school, skip ahead to ***illnesses***):

Grade in school: _____ Name of school or pre-school: _____

Best subject in school: _____ Worst subject in school: _____

Does the child do well in school? ◯ NO ◯ YES Any learning or reading problems? ◯ NO ◯ YES

Were any grades repeated? ◯ NO ◯ YES

ILLNESSES (Please select if the patient has any of the following):

◯ Chicken Pox	◯ Encephalitis	◯ Measles	◯ Meningitis	◯ Mumps	◯ Polio	◯ Removal of tonsils
◯ Rheumatic Fever	◯ Roseola	◯ Scarlet Fever	◯ Serious head trauma	◯ Tuberculosis	◯ Whooping Cough	Other: _____

REVIEW OF SYSTEMS (Please indicate if the child has had any of the following symptoms):

GENERAL:

- ☐ Weight loss
- ☐ Decreased appetite
- ☐ Fever
- ☐ Chills
- ☐ Sleep disturbance

NEURO:

- ☐ Headache, recurrent
- ☐ Fainting (Syncope)
- ☐ Seizure
- ☐ Weakness, clumsiness

EYES:

- ☐ Eye pain
- ☐ Trouble with vision

EARS:

- ☐ Ear pain
- ☐ Hearing loss

SKIN:

- ☐ Rash
- ☐ Eczema

RESPIRATORY:

- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing or asthma

GENITO-URINARY:

- ☐ Trouble with urination
- ☐ Bladder or kidney problem

GASTRO-INTESTINAL:

- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain

MUSCULOSKELETAL:

- ☐ Back pain
- ☐ Joint pain

PSYCH:

- ☐ Depression
- ☐ Anxiety

CARDIOVASCULAR:

- ☐ Chest pain
- ☐ Palpitations

HEMATOLOGY:

- ☐ Easily brusing
- ☐ Abnormal bleeding

ALLERGY:

- ☐ Allergy to medication
- ☐ Reaction to medication

PRESENT TREATMENT: please list all medications the child is ***currently*** taking.

MEDICATION	DOSE/FREQUENCY	YEARS/MONTHS TAKEN	REASON PRESCRIBED

Allergies to medications? ◯ NO ◯ YES If yes, please list medications and reaction below:

Other physicians or health care workers seen by patient and reasons:

HOSPITALIZATIONS:

When	Where	Why

Patient Name:

IMMUNIZATIONS: Is your child's immunizations complete? (Please list ***dates*** below): ◯ NO ◯ YES

If no, please complete below ***(list dates next to each immunization)***. If yes, please skip ahead to ***social history.***

IMMUNIZATION	YES/NO	DATE COMPLETED
DPT (diphtheria, tetanus, whooping cough)		
Three doses of polio vaccine		
MMR (Measles vaccine)		
Abnormal Skin test for tuberculosis		
Other immunizations, please list		

SOCIAL HISTORY:

Does your child get along well with other children? _____

Who does your child live with? _____

ADDITIONAL COMMENTS/INFORMATION: Please note any other information you feel is pertinent to the child's health and current illness:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

This history form was completed by: (Printed Name) _____ Date: _____

Signature: _____

Patient Name: