Pediatric Specialists of Texas | Neurosurgery New Patient History Questionnaire

Please complete this questionnaire to the best of your knowledge. This will allow the physician to get to know more about the patient and his/her medical condition. This questionnaire is confidential and will be kept as part of your medical record.

Date: _____/_____/______

Patient Name: ____ DOB: _____/____/_____ Age: _______________

Address: ____

Phone Numbers: (H) ______________________ (W) ________________________ (Cell) ________________________

Father's Name: _____________________________________ Mother's Name: _________________________________

BIRTH HISTORY:

Birth Weight: ________lbs ________oz Birth Height: _______________ Head Circumference:______________

Delivery : [ ] C-Section [ ] Vaginal

1) Was there a history of maternal infection or problems during pregnancy? Yes / No / Not sure
If "Yes", please describe: ____
____

2) Was there exposure to x-rays? Yes / No / Not sure
To maternal medication? Yes / No / Not sure
If "Yes", what medications? ____
____

3) History of Prematurely? Yes / No If "Yes", how many weeks? ____

4) Was intensive Care required after birth? Yes / No / Not sure
If "Yes", how long? ____

5) Was respirator support required for breathing? Yes / No/ Not sure
If "Yes", how long? ____

6) Was there a history of a brain hemorrhage? Yes / No / Not sure

7) Other complications:
A) Pregnancy: ____
B) Birth mother: ____
C) Child: ____

8) Does your child have any birthmarks? Yes / No
If "Yes", please indicate where they are located: ____
____

DEVELOPMENTAL HISTORY: (if under 5 years of age)

Please indicate what age (months or years) your child could do the following:

a) Roll over ________________
b) Sit unsupported ________________
c) Began to pull up to walk ________________
d) Stood unsupported ________________
e) Began saying Mama or Dada ________________
f) Could say other words ________________
g) Began to feed him/herself ________________
h) Drank from a cup ________________
i) Began to dress him/herself ________________

PAST MEDICAL HISTORY:

1) Please list all previous illnesses your child has had: ____
____
____

2) Does your child have a history of seizures? Yes / No
If "Yes", please describe: ____
____
____

3) Please list and describe any surgery your child has undergone, including dates and name of procedure:
____
____
____

4) List all medications your child currently takes: ____
____
____

5) Is your child allergic to Iodine? Yes / No

6) Is your child allergic to Shellfish? Yes / No

7) List all allergies to medication: ____
____

8) Are your child's immunizations up to date? Yes / No

9) Please list any additional information you think we should know: ____
____
____

FAMILY INFORMATION:

1) Please list all siblings:

Name: ____ Date of Birth: ____________________________________
Name: ____ Date of Birth: ____________________________________
Name: ____ Date of Birth: ____________________________________
Name: ____ Date of Birth: ____________________________________

2) Is there any family history of neurological illnesses? Yes / No

If "Yes", please list the family member affected (relationship to child) and the illness: ______________________________
____
____

CHILD'S SCHOOL PROGRAM / SCHEDULE

School Name: ____ Grade / Class: ______________________________

School District: ____

School Contact Person: _________________________________ Phone Number: _____________________________

School Services: ____

PRIMARY CARE PHYSICIAN INFORMATION

Name of PCP: ____

Physician's Address: ____

Physician's Phone Number: ____

Parent/Guardian Signature: ____

Parent/Guardian Name: ____ Date: ________________
(Please Print)

Staff Only:	
Information Reviewed By:______________________________________	Date: ____________________________