Adult & Child Neurology

Medical Associates, Inc.

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HEALTH HISTORY QUESTIONNAIRE

Name: _____ Age: _____ Date of Birth: _____

Height: _____ Weight: _____ Today's Date: _____

REASON FOR VISIT: (Please describe):

_____

_____

_____

PAST MEDICAL HISTORY (Please complete all sections to the best of your knowledge. Skip those not applicable):

Birth Place/Hospital _____ Birth Weight _____ Apgar score _____

☐ Full Term or ☐ Premature _____weeks/months ☐ Vaginal Delivery or ☐ Cesarean Section

Complications with pregnancy or delivery: _____

Illnesses and/or Medical Conditions	Age

Previous Surgeries	Date

Allergies	Reactions

Current Medications	Dosage

PHARMACY INFORMATION

NAME: _____

ADDRESS: _____

_____

PHONE/FAX: _____

SOCIAL HISTORY:

Education:

School Name: _____

Grade Level: _____

☐ Academic Assistance ☐ IEP ☐ 504 Plan

Tobacco Usage (years): _____

Alcohol Usage (year): _____

Lives With:

☐ Father age: _____ ☐ Mother age: _____

☐ Brother age: _____ ☐ Sister Age: _____

☐ Brother age: _____ ☐ Sister Age: _____

☐ Other: _____

Place a ✓ next to any of the following tests done.

		Location	Date
EKG	☐	_____	_____
Lumbar Puncture	☐	_____	_____
Head MRI	☐	_____	_____
Spine MRI	☐	_____	_____
Head CT	☐	_____	_____
Electroencephalogram (EEG)	☐	_____	_____
Blood Test (including genetic testing)	☐	_____	_____
Other Tests	☐	_____	_____

FAMILY HISTORY:

Ethnic background: Mother:_____ Father:_____

Legend: MGM = Maternal Grandmother; MGF = Maternal Grandfather; PGM = Paternal Grandmother; PGF = Paternal Grandfather

Illness/ Condition	Father	Mother	Brother	Sister	Brother	Sister	MGM	MGF	PGM	PGF	Aunts	Uncles	Cousins	Describe
Developmental Delays	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
ADD/ADHD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Autism	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Seizures	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Fainting Spells	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Heart Disease	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stroke	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Migraine Headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Motion sickness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Motor Tics	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Anxiety	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Genetic Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

Developmental Assessment:

Age:

_____ Roll over
_____ Reached and grabbed
_____ Sat Independently
_____ Crawled
_____ Pulled to Stand
_____ Stood Independently
_____ First Steps
_____ Cruised

Age:

_____ Babbled
_____ First Words
_____ 3-5 word Vocabulary
_____ 15-20 word Vocabulary
_____ 50-100 word Vocabulary
_____ 2-3 word Sentences
_____ Finger Feed
_____ Feeds self with spoon
_____ Toilet Trained

Review of Systems: (Mark any that apply for the patient)

REVIEW OF SYSTEM	YES	NO		YES	NO		YES	NO
GENERAL			**STOMACH**			**NEUROLOGICAL**		
Headaches	☐	☐	Trouble swallowing	☐	☐	Stroke	☐	☐
Lethargy/Weakness	☐	☐	Heartburn/Indigestion	☐	☐	Seizure	☐	☐
Chills/Night sweats	☐	☐	Change in bowel habits	☐	☐	Head injury	☐	☐
Fever	☐	☐	Loose stool/diarrhea	☐	☐	Memory loss	☐	☐
Fainting spells/unconscious	☐	☐	Frequent stomach pain	☐	☐	Confusion	☐	☐
Weight loss	☐	☐	Vomiting	☐	☐	Trouble speaking	☐	☐
Dizziness	☐	☐	Constipation	☐	☐	Trouble swallowing	☐	☐
EYES/ VISION			**WOMEN'S HEALTH**			Unsteady gait	☐	☐
Wears glasses	☐	☐	Are you pregnant?	☐	☐	Trouble walking	☐	☐
Eyesight worsening	☐	☐	Irregular menstrual period	☐	☐	Arm/leg weakness	☐	☐
Double Vision	☐	☐	Age of 1st period:	☐	☐	Arm/leg tingling	☐	☐
Eye pain	☐	☐	Breast discharge	☐	☐	Arm/leg numbness	☐	☐
EARS/NOSE/THROAT			**SKIN**			Loss of urine control	☐	☐
Deafness	☐	☐	Rashes	☐	☐	**PSYCHIATRIC**		
Ringing in ears	☐	☐	Birthmarks	☐	☐	Nervous breakdown	☐	☐
Congestion/sneezing	☐	☐	Sores	☐	☐	Panic attacks	☐	☐
Sinus trouble/hay fever	☐	☐	Hair loss	☐	☐	Cry often/depression	☐	☐
Nose bleeds	☐	☐	**MUSCLE/BONE**			Worry a lot	☐	☐
Sore throat or tongue	☐	☐	Back pain	☐	☐	Considered suicide	☐	☐
Hoarse voice	☐	☐	Neck pain	☐	☐	Loss of interest in eating	☐	☐
Dental problems	☐	☐	Aching muscle/joints	☐	☐	Anxiety/tension	☐	☐
HEART			Shoe lift or brace (including AFO)	☐	☐	Loss of energy/fatigue	☐	☐
Chest pain with exertion	☐	☐	**HEMATOLOGIC**			**SLEEP**		
Heart murmur	☐	☐	Blood disease	☐	☐	Dreams/sleepwalk	☐	☐
Heart racing/palpitations	☐	☐	Enlarged glands	☐	☐	Legs twitch	☐	☐
Irregular heart beat	☐	☐	Bleed/bruise easily	☐	☐	Insomnia	☐	☐
High blood pressure	☐	☐	Anemia/low blood	☐	☐	Daytime drowsiness	☐	☐
LUNG/RESPRITORY			**ENDOCRINE**	☐	☐	Snores	☐	☐
Shortness of breath	☐	☐	Unwanted weight change	☐	☐	Breath holding/ gasping	☐	☐
Chest pain	☐	☐	Change in skin	☐	☐	Restless sleep	☐	☐
Chronic cough	☐	☐	Excessive thirst	☐	☐	Bed wetting	☐	☐
			Excessive tiredness	☐	☐			

For any **YES** answers please explain: _____

_____

_____

_____

_____

_____

_____