DIVISION OF CHILD AND ADOLESCENT NEUROLOGY
SIU SCHOOL OF MEDICINE
Medical History Questionnaire

Patient's Name________________________ Date of Birth:______________

Age______________ Gender: M________ F________

Please tell me your reason for wanting this clinic visit:________________________

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____

____

Parent/Guardian____

Address____

____

____

Telephone: Home________________ Work________________

Referring physician____

Physician's address____

____

____

Other physicians you want to receive a consultation report:

Name________________________ Name________________________

Address________________________ Address________________________

________________________ ________________________

________________________ ________________________

Name________________________ Name________________________

Address________________________ Address________________________

________________________ ________________________

____

PAST MEDICAL HISTORY

Please list any SURGERIES your child has had:

1. ______________________ Reason for operation ______________ Date/Hospital __________
2. ______________________ Reason for operation ______________ Date/Hospital __________
3. ______________________ Reason for operation ______________ Date/Hospital __________
4. ______________________ Reason for operation ______________ Date/Hospital __________
5. ______________________ Reason for operation ______________ Date/Hospital __________
6. ______________________ Reason for operation ______________ Date/Hospital __________
7. ______________________ Reason for operation ______________ Date/Hospital __________
8. ______________________ Reason for operation ______________ Date/Hospital __________

Please list any major MEDICAL CONDITIONS for which he/she is actively being treated.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

HOSPITALIZATIONS – Please list any hospitalizations that your child has had that have been for non-surgical reasons, i.e. for pneumonia, etc.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

CURRENT MEDICATIONS – Please bring all of your child's medications with you to your appointment

Name	Dosage/tablet (number of milligrams)	# of tablets (taken per dose)	# of times (taken per day)	Date Started (month/year)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

ALLERGIES – Please list all of your child's medication allergies including the type of reaction to any type of medication. List any adverse reactions to food substances or other types of allergens.

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____

____

IMMUNIZATIONS – Please list your child's immunizations and the date or reasonable approximate time:

____

____

____

____

BIRTH HISTORY – Please describe any complications or hospitalizations:

Birth weight______________________________

Weeks gestation______________________________

Apgar scores______________________________ Number of days in hospital______________________________

Number of previous pregnancies______________________________

Number of live births______________________________

Miscarriages______________________________

Complications to pregnancy, labor, or delivery______________________________

____

DEVELOPMENTAL HISTORY – Please note the age at which your child achieved the following skills:

Sitting without support______________________

Crawling______________________

Rolling over______________________

Standing independently______________________

Walking______________________

Running______________________

Talking (first words)______________________

Speaking in sentences______________________

Toilet trained______________________

Do you think your child: (circle one)

Has good vision?	yes	no
Hears well?	yes	no
Is socially appropriate?	yes	no
Speaks clearly?	yes	no
Follows instructions?	yes	no
Has trouble controlling anger?	yes	no
Has problems sleeping?	yes	no
Naps during the daytime?	yes	no

Is your child right or left handed? ______________________

At what age did he/she show a hand preference?______________________

Name of school______________________

Grade level______________________

Grades/marks (circle all that apply) A's B's C's D's F's

Has your child ever been held back a grade?______________________

Does he/she attend special education classes?______________________

FAMILY HISTORY

Please tell us your family history:
Health history of the child's father

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____

____

Health history of the child's mother

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____

____

What medical history do you know about your child's:
Father's Father

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____

____

Father's Mother

____

____

____

Mother's Father

____

____

____

Mother's Mother

____

____

____

Significant history in siblings:

____

____

Are there relatives with (include relationship to patient):

Seizures________________________________

Migraine headaches________________________________

Motion sickness________________________________

Fainting________________________________

Left-handedness________________________________

Slow or delayed development________________________________

Attention-deficit problems________________________________

Learning disabilities________________________________

Tics________________________________

Mood or emotional problems________________________________

Alcohol or substance abuse problems________________________________

Muscle or nerve disease________________________________

Nerve deafness________________________________

Irregular heart rate________________________________

Family ethnic background (country of origin)

Father's side________________________________

Mother's side________________________________

Intermarriage

Between first counsins?________________________________

Between second counsins?________________________________

Other?________________________________

SOCIAL HISTORY

Where was your child born and raised?

____

Has your family been exposed to toxic substances in your neighborhood?______________

____

Please tell us your marital status (Married/Widowed/Separated/Divorced)______________

Who lives in your current household?______________________________

Do you feel your household is safe?

____

____

Has any relative, co-worker, friend or pastoral person, etc. ever advised you to reduce your substance use?

____

Does anyone in your household smoke cigarettes?__________ If so, who?______________

Have you traveled with your child:

Out-of-state?________ If so, where & when:______________________

Out-of-the-country?________ If so, where & when:______________________

Do you live near white-tailed deer?______________

Do you think your child:

Smokes cigarettes?______________

Drinks alcohol?______________

Does your child drink well water or city water?______________________

REVIEW OF SYSTEMS

Please tell us if your child has problems with the following:

SKIN: rash, hives, cancers, growths, birthmarks, prolonged bleeding, easy bruisability?

____

HEAD: frequent headaches, head trauma, strokes, loss of vision, neck problems?

____

EARS: ringing, dizziness, loss of hearing, infections?

____

NOSE: nasal stuffiness, sneezing, itching, runny nose, frequent bloody noses?

____

MOUTH/THROAT: sores or lesions on the tongue or cheeks, difficulty swallowing, strep throat infections?

____

BREASTS: any noticeable lumps, discharge, or asymmetry in the appearance of the breasts?

____

RESPIRATORY: cough, wheezing, coughing up blood, sharp pains in the chest, shortness of breath on exertion, night sweats?

____

CARDIOVASCULAR: chest pain on exertion, palpitations, loss of consciousness, any doctor comment on heart murmur, shortness of breath on exertion?

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GI: difficulty swallowing, painful swallowing, pain in the abdomen, change in the bowel habits, blood in the stools, weight loss, vomiting, heartburn, vomiting blood, diarrhea, constipation, jaundice?

____

GENITOURINARY: painful urination, blood in urine, urinating frequently, incontinence, sexual difficulties, sexually transmitted diseases, testicular swelling or lumps, night time urination, menstrual difficulties, abnormal pap smears, vaginal discharge, kidney or bladder infections, incontinence?

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MUSCULOSKELETAL: pain in the joints, bone pain, muscle weakness, pain in the small joints in the hands, triggering of the hands or fingers, nocturnal leg cramps, stiffness in the joints?

____

ENDOCRINE: excessive thirst, excessive urination, blurred vision, night time urination, tremulousness, heat intolerance, cold intolerance, heart palpitations, excessive weight loss or weight gain?

____

General: profound fatigue, aching, night sweats, history of AIDS exposure, blood transfusions?

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ADDITIONAL INFORMATION (IF NEEDED)

Reviewed by M.D. Date