Welcome to **APNNA**
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Patient Initial Visit Pre-History Form

Patient's Name: ____

Date of Birth: __________________ Age: ____________ Date of this Visit: ____________________

Parent's Names: ____

Phone Numbers: HOME: ________________ Work: ________________ Cell: ___________________

Person filling out this form: _________________________ Relationship to patient: _______________

Primary Care Doctor: _________________________ Referring Doctor: _________________________

Other Physicians Providing Care: ____

____

Current Problems: What is your major concern? When did it start? How has it progressed? How is it interfering with your child's ability to function? Information on previous testing (MRIs or CT scans, blood work etc.)

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Current Medications and Doses:

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Medication and Other Allergies:

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Specific neurological issues:

Seizures: Yes or No(If NO, please go to next section)

Age of onset: ______________ Current frequency: ___________ Duration of seizures: _____________

Warning signs (aura): _______________ Triggers: ____

Behavior after seizure episode (post-ictal): ____

Types of seizures (describe briefly; responsive during seizures? convulsions, staring spells, muscle twitches, automatic movements like chewing or fumbling with clothes; loss of consciousness; losing bladder or bowel control? etc): ____

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Current Medications: ____

Effectiveness: ____

Prior Medications: ____

Previous Evaluations (CT, MRIs, EEGs, video EEG monitoring – where and when): ___________________

____

____

Recent blood tests: ____

____

Headaches: **Yes or No** (If NO, please go to next section)

Age of onset: ___________ Current Frequency: __________ Duration: _____________

Warning signs (aura): ____

Describe nature of headaches (location, quality, nausea or vomiting?, visual changes, sensitivity to light or noise?, triggers, what makes it better?, effect of sleep, car sickness or motion sickness?, etc.):

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Current medication: ____

Effectiveness: ____

Prior medications: ____

____

Previous Evaluations (CT, MRI, EEG, sleep study; where and when): _____________________________

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____

Past Medical History

Is the child adopted or a foster child? __________

Mother's Pregnancy History:

Mother's age: _____ How many previous pregnancies? _____ Prior difficulties? _____________

Problems during this pregnancy? ____

Delivery:

Hospital and City of birth: ____ Duration of Labor: __________

Full term or premature? _________________ Birth Weight: __________ Age at discharge: ____________

Was the baby in Intensive Care? _______________ Phototherapy for jaundice? _____________________

Complications at Delivery: ____

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____

Neonatal History: ____

____

Previous Hospitalizations: ____

____

Previous Surgeries: ____

____

Injuries or Accidents: ____

____

DEVELOPMENTAL HISTORY

Social Smile: ________ Pulled to stand: _________ Played with toys: ___________

Rolled over: ________ Cruised around furniture: ______ Words together: ___________

Sat Alone: _________ Walked Alone: ____________ Used Sentences: ___________

Crawled: _________ First Words: _____________ Removes Clothing: __________

Babbled: ___________ Toilet Trained: _____________

Describe any feeding/eating problems: ____

____

Describe any sleep problems: ____

____

Behaviors of concern (rocking, head banging, hand flapping, wringing, breath-holding, etc): _____________

____

SCHOOL / EDUCATIONAL HISTORY

Current School: ____ Grade: __________________

Does the child receive special help (IEP)? ____

____

Reading level: __________________ Math level: _______________________

Specific concerns (short attention span, impulsivity, behavioral issues): ______________________________

____

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FAMILY HISTORY

Mother's Name: ____ Age: ____________________________

Father's Name: ____ Age: ____________________________

Siblings (name, age, sex): ____

____

Other children with serious neurological illness: ____

Is there a history of following conditions in the family?

Seizures/Epilepsy: _______ Migraine Headaches: ______ Mental Retardation: ______

Learning Problems: ______ Psychiatric Disorders: ______ Birth Defects: ___________

Diabetes: ________ Strokes: ________ High Blood Pressure: ________

Vision/Hearing Problems: ______ Heart Disease: ______ Muscle Disease: _________

Other family diseases: ____

SOCIAL HISTORY

Who currently resides in the child's home? ____

Is there a known history of tobacco, alcohol, or illicit drug use? ____

Is there any litigation pending on your child's medical condition? ____

REVIEW of SYSTEMS **Reviewed By: ___________________________**

CATEGORY	PROBLEM	IF YES, PLEASE EXPLAIN
General	Weight gain or loss, Fatigue, Fever, excessive sweating, exercise intolerance, sleep problems	YES NO
Ears, Nose, Mouth, Throat	Infections, hearing, dental work, other	YES NO
Eyes	Vision changes, infections, other	YES NO
Skin	Acne, birthmarks, rashes, other	YES NO
Respiratory	Shortness of breath, asthma, cough, other	YES NO
Cardiovascular	Heart murmur, chest pain, irregular heart rate, other	YES NO
Gastrointestinal	Nausea, vomiting, constipation, diarrhea, abdominal pain, other	YES NO
Genitourinary	Urinary tract infections, increased or decreased urine output, other	YES NO
Neurological	Headache, seizures, weakness, fainting, unsteadiness, dizziness, other	YES NO
Psychiatric	Stress, irritability, depression, anxiety, hallucinations, other	YES NO
Musculoskeletal	Pain, arthritis, muscle aches, stiffness, scoliosis, other	YES NO
Hematologic/Lymphatic	Anemia, bleeding problems, enlarged lymph nodes, other	YES NO
Endocrine	Thyroid, growth problems, puberty issues, menstrual problems, other	YES NO

Any other CONCERNS not addressed elsewhere? ____

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