

# EMORY HEALTHCARE

## EMORY CHILDREN'S CENTER

CHILD'S NAME _____	DATE OF BIRTH _____
ADDRESS _____	CITY, STATE, ZIP _____
TELEPHONE NUMBER - HOME _____	TELEPHONE NUMBER - OTHER _____

NAME OF PARENT/GUARDIAN _____	NAME OF PARENT/GUARDIAN _____	
TELEPHONE NUMBER _____	TELEPHONE NUMBER _____	
WHO LIVES AT HOME WITH YOUR CHILD:		
1. _____ NAME/RELATIONSHIP	2. _____ NAME/RELATIONSHIP	3. _____ NAME/RELATIONSHIP
4. _____ NAME/RELATIONSHIP	5. _____ NAME/RELATIONSHIP	6. _____ NAME/RELATIONSHIP

Why is your child seeing a neurologist? What are your questions or concerns?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What medications has (is) your child taken for the above concern? \_\_\_\_\_

\_\_\_\_\_

Current Medications: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Immunizations: Current?  Yes  No. Missing Immunizations: \_\_\_\_\_

\_\_\_\_\_

What tests have been done?	When?	Where?	
EEG			
MRI			
CT Scan			
Genetic Testing			
Neuropsychological Testing			
Muscle biopsy			
EMG			
Drug Levels			

Physician Initials: \_\_\_\_\_  
Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

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Does your child see any of the following specialists?	Name of Physician:	Date of Last Visit
Orthopedist?		
Physical Therapist?		
Occupational Therapist?		
Speech Therapist?		
Psychologist?		
Neurosurgeon?		
Geneticist?		
Other?		

Who is your pediatrician or family doctor? \_\_\_\_\_  
Address: \_\_\_\_\_  
Telephone Number: \_\_\_\_\_

**MEDICAL HISTORY:** Birth History: (Describe any complications with labor/delivery and post delivery – child on ventilator, NICU, surgery in first six months of life...) \_\_\_\_\_  
\_\_\_\_\_  
Birth Weight: \_\_\_\_\_ Mother's age at child's birth: \_\_\_\_\_ Birthmarks: \_\_\_\_\_ Where? \_\_\_\_\_

**MILESTONES:** At what age did your child:  
Walk? \_\_\_\_\_ Talk? \_\_\_\_\_

**SURGICAL HISTORY:** Has your child had any surgeries:

Type of surgery:	When?	Where?

Physician Initials: \_\_\_\_\_  
Date: \_\_\_\_\_

CHILD'S NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

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Does your child have any other medical problems?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY:** Is there a family history of neurological problems?

Problem	Who	At what Age	Gender
Seizures			
Migraine Headaches			
Movement Disorders			
Learning Problems			
Other?			

SYSTEMS: Mark box indicating normal/abnormal.	NORMAL	ABNORMAL	EXPLAIN - IF ABNORMAL
1. General Health			
2. Skin/Birth Marks			
3. Head			
4. Ears			
5. Eyes			
6. Nose			
7. Neck			
8. Respiratory/Breathing			
9. Heart/Circulation/Blood			
10. Abdomen/Digestion			
11. Genitalia			
12. Muscles/Bones			
13. Endocrine/Glands			
14. Neurological			
15. Behavior/Learning			
16. Other			

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Physician Initials: \_\_\_\_\_  
Date: \_\_\_\_\_