Banner Health®

NEW PATIENT MEDICAL HISTORY - PEDIATRIC NEUROLOGY-HEADACHES

Patient Name: _____ DOB: _____/_____/_____

Patent/Guardian names: _____

The following questions relate to your general health. The details of this form will only be reviewed by your physician and nurse. Please bring this form to your appointment.

Referred for Consultation by: _____

Preferred Pharmacy: (name and location) _____

Medications (Including Vitamins, Supplements, and Over the Counter Medication)

❑ No Medications

1) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

2) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

3) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

4) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

5) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

6) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

7) _____ Dosage: _____ # of Time a Day: _____ Date Started: _____
Conditions being treated with above Medication _____

Please list all medications you have tried in the past for your headaches:

Medication	Dose	Frequency	Dates Taken	Why Discontinued?

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Headache History

How long have you had headaches? _____

How long do your headaches last? _____

How would you rate your headaches, on a scale of 1-10 (10 being the worst)? _____

How many days in the past month did you have a headache? _____

Status: ❑ Improving ❑ No Change ❑ Resolved ❑ Worse

Frequency: ❑ Constant ❑ Intermittent ❑ Daily ❑ Weekly ❑ Monthly

Location:

❑ Entire Head
❑ Frontal Left
❑ Ocular Left
❑ Parietal Left
❑ Temporal Left
❑ Occipital
❑ Frontal Right
❑ Ocular Right
❑ Parietal Right
❑ Temporal Right
❑ Vertex

Other: _____

Radiation:

❑ None
❑ Anterior
❑ Posterior
❑ Neck
❑ Shoulders
❑ Upper Thorax

Other: _____

Quality:

❑ Blinding
❑ Debilitating
❑ Dull
❑ Lancinating
❑ Pressure
❑ Superficial
❑ Sharp
❑ Squeezing
❑ Stabbing
❑ Throbbing
❑ Worst Ever

Other: _____

Timing:

❑ Daytime
❑ Menstrual Periods
❑ Upon Awakening
❑ Weekday
❑ Weekend

Other: _____

Aggravating Factors

❑ None
❑ Allergies
❑ Anxiety
❑ Bright Lights
❑ Caffeine
❑ Exercise
❑ Head Position
❑ Food
Type(s) _____
❑ Noise
❑ Stress
❑ Valsalva
❑ Weather

Other: _____

Relieving Factors:

❑ Nothing
❑ Analgesics
❑ Bath
❑ Darkness
❑ Decongestants
❑ Distraction
❑ Heat
❑ Ice
❑ Massage
❑ OTC Meds
❑ Position
❑ Prescription Drugs
❑ Relaxation
❑ Sleep
❑ Stretching

Other: _____

Context:

❑ Family Hx of Migraine
❑ Hx of Migraine
❑ Recent Head Trauma
❑ Recent MVA

Other: _____

Associated Symptoms/Pertinent Negatives:

❑ No associated Symptoms
❑ Blurred Vision
❑ Clear Sinus Drainage
❑ Dizziness
❑ Double Vision
❑ Fever
❑ Hemianopsia Left
❑ Hemianopsia Right
❑ Loss of Consciousness
❑ Memory Impairment
❑ Nausea
❑ Neck Stiffness
❑ Neurological symptoms
❑ Performance Changes
❑ Personality Change
❑ Phonophobia
❑ Photophobia
❑ Scintillations
❑ Scotoma
❑ URI like Symptoms
❑ Vertigo
❑ Vision Loss Right
❑ Vision Loss Left
❑ Visual Aura
❑ Vomiting

Other: _____

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Family History

Do headaches, other neurological disorders, depression, anxiety, or heart problems run in your family? If so, please explain who and what they have or had? _____

_____

Family History - Please list any relatives that have or have ever had these or other health conditions in their lifetime. Please note if they are deceased due to any specific condition. Please include the family members listed below:

Mother - Father - Sister - Brother - Grandparents - Other Family Member - Family HX if member unknown

ADD/ADHD _____	Alcoholism _____	ALS _____
Alzheimer's _____	Asthma _____	Heart Disease _____
Cancer/Type _____	CNS Malignancy _____	Congestive Heart Failure _____
CVS Stroke _____	Dementia _____	Depression _____
Developmental Delays _____	Deafness _____	Diabetes _____
Epilepsy _____	Genetic Disorders _____	Headaches _____
Hearing Impairment _____	HIV _____	Huntington's Chorea _____
Hyperlipidemia _____	Inflammatory Bowel Dz _____	Learning Disabilities _____
Liver Disease _____	Mental Disabilities _____	Migraines _____
Multiple Sclerosis _____	Myocardial Infarction _____	Peripheral Nerve Dz _____
Renal Disease _____	Seizure Disorder _____	SIDS _____
Schizophrenia _____	Scoliosis _____	Spinal Dz, Cervical _____
Spinal Dz, Lumbar _____	Thyroid Disorder _____	Tuberculosis _____

Other _____

_____

Neurological Imaging

Have you had a CAT scan, EEG, or MRI of your head and neck in the past 3 years? ❑ Yes ❑ No

If yes, please bring the report and image to your initial visit.

Social History

Describe your living situation (house/condo/apartment) _____

Language spoken at home _____

Parents marital status: _____ Resides with: _____

If parents are separated or divorced, who has custody of this child _____

Is there a Secondary residence? ❑ Yes ❑ No

Mother's Name _____ Stepmother? ❑ Yes ❑ No

Address _____

Home Phone _____ Work Phone _____

Father's Name _____ Stepmother? ❑ Yes ❑ No

Address _____

Home Phone _____ Work Phone _____

Number of Siblings:

Brother(s) _____ Names: _____

Sister(s) _____ Names: _____

List other Individuals living in the home: _____

Do you smoke? ❑ Yes ❑ No If so how much? _____

Do you drink alcohol? ❑ Yes ❑ No If so how much? _____

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Sexually Active? ❑ Yes ❑ No

What school and grade are you in? _____
Performing At _____, Below _____, Above _____ Grade Level.
Have you missed school because of your headaches? ❑ Yes ❑ No

Do you eat three meals a day, if not which ones do you skip? _____

Do you own a cell phone? ❑ Yes ❑ No If so, how many texts per month? _____

Where do you keep your cell phone at night? _____

Do you drink caffeinated beverage? ❑ Yes ❑ No
If so which ones, and how much, and how often? _____

_____

How much water do you drink in a day? _____

Do you exercise? ❑ Yes ❑ No If so, what kind, how long and how often? _____

_____

What time do you go to sleep and when do you wake up? _____

_____

Review of Systems

(Please circle YES to any of the following you may have experienced **in the past 3 months and explain in remarks section)**

GENERAL		
Fever, chills, night sweats	YES	NO
Weight change more than 10 lbs.	YES	NO
Overwhelming fatigue	YES	NO
EYES		
Temporary vision changes	YES	NO
Permanent vision changes	YES	NO
Blurry vision	YES	NO
Seeing spots or lines of light	YES	NO
Pain in eyes	YES	NO
Increased/Decrease Tearing	YES	NO
Double Vision	YES	NO
HEENT		
Scalp Tenderness	YES	NO
Ear pain	YES	NO
Ringing in the ears	YES	NO
Hearing loss	YES	NO
Vertigo (feeling like the room is spinning)	YES	NO
Pain or numbness in face	YES	NO
Problems with speech or slurred speech	YES	NO
Sore throat	YES	NO
Nasal Congestion	YES	NO
Sinus pain or pressure	YES	NO
CARDIOVASCULAR		
Chest pain	YES	NO
Racing heart rate or irregular heart beat	YES	NO
Pain in legs with walking	YES	NO

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LUNGS		
Cough	YES	NO
Shortness of breath	YES	NO
ABDOMEN		
Abdominal Pain	YES	NO
Nausea/Vomiting	YES	NO
Heartburn	YES	NO
Diarrhea/Constipation	YES	NO
Pain or trouble with swallowing	YES	NO
Blood in stool	YES	NO
FEMALE		
Abnormal menses	YES	NO
Pelvic pain	YES	NO
Recent pregnancy	YES	NO
GU		
Trouble with urinary stream	YES	NO
Pain with urination	YES	NO
Frequency of urination	YES	NO
Erectile dysfunction (males)	YES	NO
SKIN		
Rash	YES	NO
Suspicious lesions	YES	NO
PSYCH		
Feeling sad or down	YES	NO
Feeling anxious or worried	YES	NO
Poor sleep	YES	NO
Feeling overwhelmed	YES	NO
Difficulty concentrating	YES	NO
Mood swings	YES	NO
NEUROLOGIC		
Weakness in arms, legs, or face	YES	NO
Loss of consciousness	YES	NO
Memory problems	YES	NO
Numbness or tingling	YES	NO
Seizure	YES	NO
Poor balance	YES	NO
Tremor	YES	NO
MUSCULOSKELETAL		
Muscle pain	YES	NO
Low back pain	YES	NO
Neck pain	YES	NO
Shoulder pain	YES	NO
Other joint pain, stiffness, or swelling	YES	NO

Review of Systems Remarks (if YES to any of the above, please specify below):

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