UFHealth
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University of Florida Pediatric Neurosurgery
Patient Health History

Please fill out this form as best as you can and bring it to your child's next appointment.

Patient Name: ____

Medical Record Number: _____________ Date of Birth: _____/_____/_____ Age: ______

HISTORY OF PRESENT ILLNESS:
Please describe the **major problem** or **problems** that brings your child in to see a neurosurgeon:

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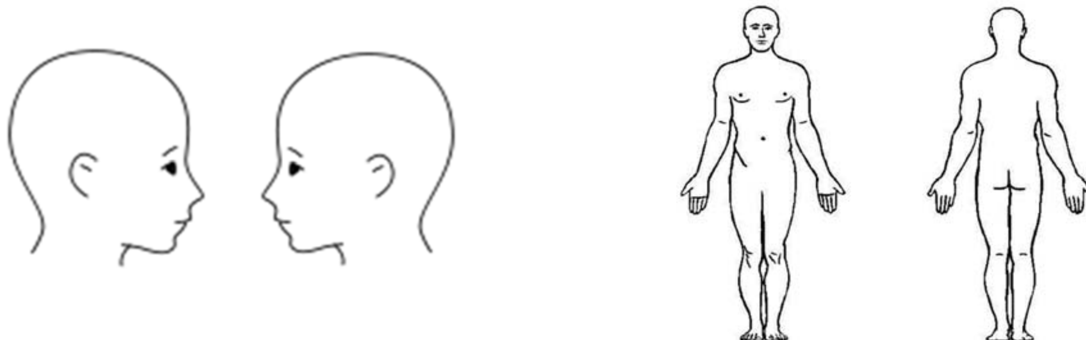
The current problem is a result of an:

- ☐ Accident
- ☐ Car accident
- ☐ Other: ____

Please indicate the average amount of daily pain your child has due to this condition:

Please indicate by shading on the diagrams below where your child's pain is usually located.



Please fill out with patient's information unless stated otherwise.

Birth History:

Length at birth: ___________________ Birth weight: ___________________

Delivery method: ___________________ Duration of labor: ___________________

Gestational age: ___________________ Birth head circumference: ___________________

Feeding method: ___________________

Additional comments:

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Medical History:

List your child's medical diagnoses and their date, if any, or check box if none ☐.

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Surgical History:

List any surgeries your child has had including month and year, or check box if none ☐.

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Family History:

Are there any diseases that run in the child's family? Circle yes or no, and if yes, please explain.

Mother **Yes** **No** Father **Yes** **No** Siblings **Yes** **No** Other **Yes** **No**

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Other History: **Circle one:**

Is your child up to date on immunizations?	**Yes**	**No**
Has your child ever had problems with anesthesia?	**Yes**	**No**

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Home Environment:

Lives with biological parent(s)	**Yes**	**No**
Foster care	**Yes**	**No**
Legal guardian's name	______________________________	
Number of people in patient's home	______________________________	

Substance Use:

Tobacco	**Yes**	**No**
Alcohol	**Yes**	**No**
Drugs	**Yes**	**No**

Allergies:

List anything your child is allergic to and the reaction to the allergy, or check box if none ☐.

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Medications:

List all the medications your child routinely takes, or check box if none ☐. This includes vitamins, supplements, and over-the-counter medicine.

Medication	Strength	Dosage	Frequency

Is your child currently taking anti-inflammatory medication(s), Aspirin, or a medication that contains Aspirin? (E.g. Advil, Motrin, Aleve) **Yes** **No**

If yes, what medication?

____

____

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Review of Systems:

Circle yes or no:

Constitutional

Fatigue	**Yes**	**No**
Fever	**Yes**	**No**
Weight loss	**Yes**	**No**
Weight gain	**Yes**	**No**

Eyes

Change in vision	**Yes**	**No**
Double vision	**Yes**	**No**

Ear, Nose, Throat

Hearing loss	**Yes**	**No**
Trouble swallowing	**Yes**	**No**
Change in voice	**Yes**	**No**

Cardiorespiratory

Chest pain	**Yes**	**No**
Shortness of breath	**Yes**	**No**
Apnea	**Yes**	**No**
Cough	**Yes**	**No**

Gastrointestinal

Nausea	**Yes**	**No**
Vomiting	**Yes**	**No**
Diarrhea	**Yes**	**No**
Constipation	**Yes**	**No**
Abdominal pain	**Yes**	**No**
Bowel accidents	**Yes**	**No**

Urinary

Frequent urination	**Yes**	**No**
Bladder accidents	**Yes**	**No**

Endocrine

Sweating	**Yes**	**No**
Heat intolerance	**Yes**	**No**
Cold intolerance	**Yes**	**No**
Nipple discharge	**Yes**	**No**

Musculoskeletal

Back pain	**Yes**	**No**
Neck pain	**Yes**	**No**

Neurologic

Headaches	**Yes**	**No**
Seizures	**Yes**	**No**
Dizziness	**Yes**	**No**
Tremors	**Yes**	**No**
Weakness	**Yes**	**No**
Numbness	**Yes**	**No**
Tingling	**Yes**	**No**

Cognitive

Memory loss	**Yes**	**No**
Language difficulty	**Yes**	**No**
Confusion	**Yes**	**No**
Anxiety	**Yes**	**No**
Depression	**Yes**	**No**
Insomnia	**Yes**	**No**

The above information about my child is accurate to the best of my knowledge.

____

Parent/Guardian Signature Date

Patient Name: ___________________________________ **Date of Birth:** _____________

Referring Doctor: ____

Company: ____

Address: ____

____

Telephone: ____

Fax: ____

Primary Care Doctor: ____

Company: ____

Address: ____

____

Telephone: ____

Fax: ____

Pharmacy Name: ____

Address: ____

____

Telephone: ____

Fax: ____