The Comprehensive Neurofibromatosis Clinic

NewYork-Presbyterian
Phyllis and David Komansky Center for Children's Health
Weill Cornell Medical Center

Weill Cornell Medical Center
New York Presbyterian Hospital
505 E 70th Street 3rd Floor
New York, NY 10021
Phone: 212-746-3278
Fax: 212-746-8137
Email: cornellnf@med.cornell.edu

Kaleb H. Yohay, MD
Director

QUESTIONNAIRE
Please complete this questionnaire. It will be an important part of your child's medical record.

Patient Name: Today's Date:

DOB: Age: MR #:

Name of Person Completing Questionnaire:

Relationship to Patient:

☐ **Pediatrician**:
Address: Telephone:

☐ **Referring Physician**:
Address: Telephone:

If you were not referred to the NF clinic by a physician, who suggested you come here, or how did you find out about our clinic?

We will send copies of your reports to the *Referring Physician* and *Primary Care Physician* listed above. Is there anyone else who should receive copies?
Name: Specialty:

Address: Telephone: Fax:

Please bring to your appointment any and all reports of previous neurological testing or consultation, or reports of significant past medical problems.
If your child ever had a brain x-ray, CT, or MRI, please borrow the films or obtain a copy of the films and bring them with you to the visit.

CHIEF COMPLAINT: (Please describe the reason for your appointment.)

Has your child been previously diagnosed with:

Neurofibromatosis type 1? ☐ Yes ☐ No (please answer questions 1 – 13 below)

Neurofibromatosis type 2? ☐ Yes ☐ No (please answer questions 14 – 25 below)

None of the above/I don't know ☐ Yes ☐ No (please answer questions 1 – 13 below)

HISTORY OF PRESENT ILLNESS: (Neurofibromatosis type 1)

1. If applicable, how old was your child when he/she was diagnosed with neurofibromatosis type 1 (NF1)?

2. Does your child have any café-au-lait spots (flat light brown spots on the skin)? If so, where?

3. Does your child have any freckling around the groin or armpits?

4. Does your child have any neurofibromas (lumps on the surface or under the skin)? If so, where and what kind?

   Have any been biopsied? ☐ Yes ☐ No

   Do they itch or cause pain? ☐ Yes ☐ No

   Do they cause any limitation of function? ☐ Yes ☐ No

   Does their appearance bother you or your child? ☐ Yes ☐ No

5. Has your child ever been diagnosed with scoliosis (curvature of the spine) or other bone/orthopedic problems? ☐ Yes ☐ No

6. Has your child ever been diagnosed with or treated for high blood pressure? ☐ Yes ☐ No

7. Has your child ever been diagnosed with or treated for learning problems or attention deficits? ☐ Yes ☐ No

8. Has your child been diagnosed with Lisch nodules by an ophthalmologist? ☐ Yes ☐ No

9. Has your child ever been diagnosed with an optic pathway glioma? ☐ Yes ☐ No

10. When was your child last evaluated by an ophthalmologist?

    What were the results?

11. Has your child ever had scans of the brain and/or spine (MRI or CT)? If so, when and where? For what reason? ☐ Yes ☐ No

12. Does your child have or has your child ever had seizures? ☐ Yes ☐ No

13. Does your child have headaches? ☐ Yes ☐ No

HISTORY OF PRESENT ILLNESS: (Neurofibromatosis type 2)

14. If applicable, how old was your child when he/she was diagnosed with neurofibromatosis type 2 (NF2)?

15. Has your child been diagnosed with vestibular schwannomas (acoustic neuromas)? ☐ Yes ☐ No

If so, when?
Has your child had surgery or radiation therapy? ☐ Yes ☐ No

16. Does your child have hearing loss?
☐ Yes ☐ No

17. When was your child's last hearing test?
What were the results?

18. Does your child use American Sign Language?
☐ Yes ☐ No

19. Has your child ever been diagnosed with meningiomas?
☐ Yes ☐ No

20. Has your child ever been diagnosed with schwannomas?
☐ Yes ☐ No If so, where are they located?
Have any been biopsied or surgically removed?

21. Has your child ever been diagnosed with tumors of the spinal cord?
☐ Yes ☐ No

22. Do any of your child's tumors/schwannomas cause pain?
☐ Yes ☐ No

23. Has your child ever had scans of the brain and/or spine (MRI or CT)? ☐ Yes ☐ No

If so, when and where? For what reason?

24. Does your child have or has your child ever had seizures? ☐ Yes ☐ No

25. Does your child have headaches?
☐ Yes ☐ No

Others Symptoms

Please describe any other symptoms your child is experiencing or have had in the past

BIRTH HISTORY:
What was the patient's birth weight? lbs ounces

Was the patient born prematurely? ☐ Yes ☐ No If yes, how many weeks premature?

Were there any problems during delivery? ☐ Yes ☐ No

If yes, please describe:

Did the patient have any problems in the newborn period (first month of life)? ☐ Yes ☐ No
If yes, please describe:

How long did your child stay in the hospital after birth?

DEVELOPMENTAL HISTORY:

At what age did your child:
Smile:
Roll Over:
Sit independently:
Start Cruising:
Walk:
Babbling:
First Words:
First Phrases:

Have you ever had any worries about abnormal or slow development in your child? ☐ Yes ☐ No

If yes, please describe at what age you first became concerned , and what symptom(s) made you worry about development:

Has your child ever lost developmental skills? ☐ Yes ☐ No
If yes, please describe at what age the skills were lost and which skills were lost:

Has your child ever been part of any diagnosis of a specific developmental problem or handicapping condition (for example, cerebral palsy, learning disability)? ☐ Yes ☐ No
If yes, please describe:

Does your child receive any specialized developmental treatment services or special education program (for example, physical therapy or special classroom placement)? ☐ Yes ☐ No
If yes, please describe:

What is your child's current educational placement (school, grade level)?

FAMILY HISTORY:
For each family member, please list current age and medical problems; if deceased, list the cause and age of death. Please note any family members with known neurofibromatosis, café-au-lait spots, neurofibromas (bump on the skin) or other tumors.

Immediate Family:
Mother:

Father:

Brothers:

Sisters:

Mother's Extended Family:
Maternal Aunts:

Maternal Uncles:

Maternal Cousins:

Maternal Grandmother:

Maternal Grandfather:

Father's Extended Family:
Paternal Aunts:

Paternal Uncles:

Paternal Cousins:

Paternal Grandmother:

Paternal Grandfather**:**

Do any of the above family members, or more distant relatives, have any known neurologic or psychiatric conditions? ☐ Yes ☐ No If yes, please describe:

CURRENT MEDICATIONS
(include over the counter, herbal therapies and vitamins)

Medication	Dose/Frequencey	Prescribed By	Taken Since

REVIEW OF SYSTEMS
Please check any conditions your child has experienced.

CONSTITUTIONAL		HEAD, EARS, NOSE, MOUTH, THROAT		CARDIOVASCULAR		HEME-LYMPHATIC	
☐Yes ☐No	Altered taste or smell	☐Yes ☐No	Balance Problem	☐Yes ☐No	Angina	☐Yes ☐No	Blood disorder
☐Yes ☐No	Change in appetite	☐Yes ☐No	Dizziness	☐Yes ☐No	Chest pain	☐Yes ☐No	Diabetes
☐Yes ☐No	Weight loss or gain	☐Yes ☐No	Ringing in the ears	☐Yes ☐No	Chest pressure	☐Yes ☐No	Endocrine disorder
☐Yes ☐No	Unable to sleep	☐Yes ☐No	Hearing loss	☐Yes ☐No	Fainting	☐Yes ☐No	Sickle Cell Disease
☐Yes ☐No	Excessive sleepiness	☐Yes ☐No	Trouble breathing through nose	☐Yes ☐No	Heart Failure	☐Yes ☐No	Thyroid Disease
☐Yes ☐No	Fatigue	☐Yes ☐No	Nasal bleeds/ discharge	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Enlarged lymph nodes
☐Yes ☐No	Recurrent Fever	☐Yes ☐No	Sinus problems	☐Yes ☐No	High blood pressure	☐Yes ☐No	HIV
		☐Yes ☐No	Mouth sores	☐Yes ☐No	Low blood pressure	☐Yes ☐No	AIDS
		☐Yes ☐No	Sore throat	☐Yes ☐No	Shortness of breath		
		☐Yes ☐No	Trouble swallowing	☐Yes ☐No	Leg swelling		
MUSCULOSKELETAL		**EYES**		**GASTROINTESTINAL**		**RESPIRATORY**	
☐Yes ☐No	Back pain	☐Yes ☐No	Blurred vision	☐Yes ☐No	Abdominal pain	☐Yes ☐No	Asthma
☐Yes ☐No	Neck pain	☐Yes ☐No	Double vision	☐Yes ☐No	Constipation	☐Yes ☐No	Bronchitis
☐Yes ☐No	Joint pain	☐Yes ☐No	Glaucoma	☐Yes ☐No	Diarrhea	☐Yes ☐No	Pneumonia
☐Yes ☐No	Joint swelling	☐Yes ☐No	Cataracts	☐Yes ☐No	Gastritis	☐Yes ☐No	Tuberculosis
				☐Yes ☐No	Hepatitis	☐Yes ☐No	Chronic Cough
				☐Yes ☐No	Hiatal Hernia		
				☐Yes ☐No	Rectal bleeding		
				☐Yes ☐No	Ulcer		
				☐Yes ☐No	Vomiting		
INTEGUMENTARY		**URINARY**		**PSYCHIATRIC**			
☐Yes ☐No	Breast disease	☐Yes ☐No	Increased frequency	☐Yes ☐No	Anxiety		
☐Yes ☐No	Skin rash	☐Yes ☐No	Incontinence	☐Yes ☐No	Depression		
				☐Yes ☐No	Trouble concentrating		
REVIEW OF SYSTEMS - NEUROLOGIC							
☐Yes ☐No	Confusion	☐Yes ☐No	Clumsiness	☐Yes ☐No	Choking	☐Yes ☐No	Blurred vision
☐Yes ☐No	Difficulty Concentrating	☐Yes ☐No	Facial numbness/tingling	☐Yes ☐No	Difficulty chewing	☐Yes ☐No	Decreased hearing
☐Yes ☐No	Dizziness	☐Yes ☐No	Numbness-arms (L/R/B)	☐Yes ☐No	Difficulty tasting	☐Yes ☐No	Diplopia
☐Yes ☐No	Hallucinations	☐Yes ☐No	Numbness-legs (L/R/B)	☐Yes ☐No	Drooling	☐Yes ☐No	Dysphagia
☐Yes ☐No	Headache	☐Yes ☐No	Poor balance	☐Yes ☐No	Hoarseness	☐Yes ☐No	Syncope
☐Yes ☐No	Lethargy	☐Yes ☐No	Poor coordination	☐Yes ☐No	Incontinence-bowel	☐Yes ☐No	Ringing in ears
☐Yes ☐No	Memory problems	☐Yes ☐No	Speech difficulty	☐Yes ☐No	Incontinence-bladder	☐Yes ☐No	Trouble with smell
☐Yes ☐No	Personality Change	☐Yes ☐No	Stiffness	☐Yes ☐No	Nausea	☐Yes ☐No	Vertigo
☐Yes ☐No	Spells	☐Yes ☐No	Trouble walking	☐Yes ☐No	Pain		
		☐Yes ☐No	Weakness-arms (L/R/B)	☐Yes ☐No	Vomiting		
		☐Yes ☐No	Weakness-legs (L/R/B)				

All others negative

DRUG ALLERGIES AND REACTIONS Is your child allergic to any medications? If so, please list the medication and his/her reaction to it.			
MEDICATION	**REACTION**	**MEDICATION**	**REACTION**

PAST MEDICAL HISTORY - SURGERIES Please list all operations your child has had, with approximate dates			
PROCEDURE	**DATE**	**SURGEON**	**RESULT**
Has your child ever had a problem with anesthesia? ☐ Yes ☐ No If so, what substance and what complication?			

Race and Ethnicity Information

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

Primary Language

☐ Albanian ☐ American Sign Language ☐ Arabic ☐ Armenian
☐ Bengali ☐ Bosnian ☐ Cantonese (Chinese)
☐ Creole ☐ Croatian ☐ ECH ☐ Danish
☐ English ☐ French ☐ German ☐ Greek
☐ Hebrew ☐ Hindi ☐ Indonesian ☐ Italian
☐ Japanese ☐ Korean ☐ Latin ☐ Malay
☐ Mandarin (Chinese) ☐ Persian ☐ Polish
☐ Portuguese ☐ Romanian ☐ Russia ☐ Serbian
☐ Slovak ☐ Spanish ☐ Swahili ☐ Swedish
☐ Tagalog ☐ Thai ☐ Turkish ☐ Urdu
☐ Vietnamese ☐ Yiddish ☐ Yugoslavian ☐ Other
☐ Declined ☐ Unknown

Race

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Island
☐ White
☐ Other Combination Not Described
☐ Declined

Ethnicity

☐ Hispanic or Latino or Spanish Origin
☐ Not Hispanic or Latino or Spanish Origin
☐ Declined

Pharmacy Information

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

☐ New

Date:

Patient Name:

NYH #:

PRIMARY

Pharmacy Name:

Address:

Phone Number:

Fax Number:

SECONDARY (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number:
