Weill Cornell Medicine
Child Neurology

NewYork-Presbyterian
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Center for Children's Health
Weill Cornell Medical Center

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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:

How did you learn about our practice?

☐ **Pediatrician**:
Address: Telephone:

☐ **Self-Referral**

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

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 COMPAINT: (Please describe the reason for your appointment.)

HISTORY OF PRESENT ILLNESS: (Please describe the problem in detail answering the following questions:

What signs or symptoms is your child experiencing?

How long have these symptoms been present?

What part(s) of the body and what functions are being affected?

How often do the symptoms occur?

Do symptoms occur at a particular time of day? If so, when?

How severe is the problem?

How long do the symptoms last?

Does anything make the symptoms get better? If so, what?

Does anything make the symptoms get worse? If so, what?

Has there been prior treatment or surgery for this problem?

PLEASE DESCRIBE ALL OTHER CURRENT MEDICAL PROBLEMS AND PAST MEDICAL ILLNESSES:

PLEASE LIST ALL PAST SURGICAL PROCEDURES WITH APPROXIMATE DATES:

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

Medication	**Dose**	**How often**

Does the patient have any allergies to medications? ☐ Yes ☐ No

If yes, please list the medications and the nature of the reactions.

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:
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
Has anyone in the patient's family (or relative) had any of the following? If yes, check the box and list the person's relationship to the patient next to the problem.

☐ Migraine headaches	☐ Brain tumors	☐ Heart Disease
☐ Seizures	☐ Cancer	☐ Strokes
☐ Intellectual Disabilities	☐ Autism	☐ Psychiatric Illness
☐ Developmental delay	☐ Attention deficit	☐ Addiction Disorders
☐ Learning Disabilities	☐ Language Delay	☐ Genetic Disorder
☐ Neuro-degenerative disorder	☐ Hypertension	☐ Epilepsy

Is there any other disease/illness that runs in the family?

SOCIAL HISTORY
Who lives in the same household with the patient?

Name	Age	Relationship to the patient

Are the parent(s) ☐ Single ☐ Separated ☐ Married ☐ Divorced ☐ Remarried

Any unusual stresses at home or at school? ☐ Yes ☐ No

If yes, please explain.

REVIEW OF SYSTEMS Please circle “yes” or “no” for each.							
GENERAL		**HEAD, EARS, NOSE, MOUTH, THROAT**		**CARDIOVASCULAR**		**GASTROINTESTINAL**	
☐Yes ☐No	Altered taste or smell	☐Yes ☐No	Large Head	☐Yes ☐No	Heart defect	☐Yes ☐No	Abdominal pain
☐Yes ☐No	Change in appetite	☐Yes ☐No	Small head	☐Yes ☐No	Chest pain	☐Yes ☐No	Constipation
☐Yes ☐No	Feeding problems	☐Yes ☐No	Abnormal Head Shape	☐Yes ☐No	Chest pressure	☐Yes ☐No	Diarrhea
☐Yes ☐No	Poor weight gain	☐Yes ☐No	Bulging soft spot	☐Yes ☐No	Fainting	☐Yes ☐No	Gastritis
☐Yes ☐No	Weight loss	☐Yes ☐No	Ringing in ears	☐Yes ☐No	Heart Failure	☐Yes ☐No	Food intolerance
☐Yes ☐No	Unable to sleep	☐Yes ☐No	Nasal discharge	☐Yes ☐No	Heart Murmur	☐Yes ☐No	Feeding problems
☐Yes ☐No	Excessive sleepiness	☐Yes ☐No	Sinus problems	☐Yes ☐No	High blood pressure	☐Yes ☐No	Bloody stools
☐Yes ☐No	Fatigue	☐Yes ☐No	Mouth sores	☐Yes ☐No	Low blood pressure	☐Yes ☐No	Colic
☐Yes ☐No	Recurrent Fever	☐Yes ☐No	Sore throat	☐Yes ☐No	Shortness of breath	☐Yes ☐No	Vomiting
		☐Yes ☐No	Hearing loss	☐Yes ☐No	Leg swelling		
MUSCULOSKELETAL		**EYES**		**ENDOCRINE**		**RESPIRATORY**	
☐Yes ☐No	Spine defects	☐Yes ☐No	Blurred vision	☐Yes ☐No	Temperature instability	☐Yes ☐No	Asthma
☐Yes ☐No	Neck pain	☐Yes ☐No	Double vision	☐Yes ☐No	Irregular menses	☐Yes ☐No	Bronchitis
☐Yes ☐No	Joint pain	☐Yes ☐No	Glaucoma	☐Yes ☐No	Diabetes	☐Yes ☐No	Chronic Lung Disease
☐Yes ☐No	Joint swelling	☐Yes ☐No	Cataracts	☐Yes ☐No	Early or late puberty	☐Yes ☐No	Pneumonia
☐Yes ☐No	Back or neck pain	☐Yes ☐No	Eye pain	☐Yes ☐No	Thyroid problems	☐Yes ☐No	Tuberculosis
☐Yes ☐No	Muscle pain					☐Yes ☐No	Chronic cough
SKIN/HAIR		**URINARY**		**BLOOD/LYMPH**		**IMMUNOLOGIC/ALLERGY**	
☐Yes ☐No	Birth marks	☐Yes ☐No	Increased frequency	☐Yes ☐No	Easy bleeding	☐Yes ☐No	Immune deficiency
☐Yes ☐No	Skin rash	☐Yes ☐No	Increased urgency	☐Yes ☐No	Easy bruising	☐Yes ☐No	Frequent infections
☐Yes ☐No	Brittle hair	☐Yes ☐No	Delayed or Regressed toilet training	☐Yes ☐No	Frequent nose bleeds	☐Yes ☐No	Severe infections
☐Yes ☐No	Easy scarring	☐Yes ☐No	Urinary Infections	☐Yes ☐No	Swollen lymph nodes	☐Yes ☐No	Poor wound healing
BEHAVIOR/PSYCHIATRIC		**NEUROLOGIC**					
☐Yes ☐No	Anxiety	☐Yes ☐No	Difficulty Concentrating	☐Yes ☐No	Clumsiness	☐Yes ☐No	Choking
☐Yes ☐No	Depression	☐Yes ☐No	Vertigo	☐Yes ☐No	Facial numbness	☐Yes ☐No	Difficulty chewing
☐Yes ☐No	Panic attacks	☐Yes ☐No	Dizziness	☐Yes ☐No	Numbness (arms)	☐Yes ☐No	Difficulty swallowing
☐Yes ☐No	Trouble concentrating	☐Yes ☐No	Headache	☐Yes ☐No	Numbness (legs)	☐Yes ☐No	Difficulty tasting
☐Yes ☐No	Hallucinations	☐Yes ☐No	Lethargy	☐Yes ☐No	Poor balance	☐Yes ☐No	Difficulty smelling
☐Yes ☐No	Suicidal thoughts	☐Yes ☐No	Memory problems	☐Yes ☐No	Poor coordination	☐Yes ☐No	Drooling
☐Yes ☐No	Confusion	☐Yes ☐No	Convulsions	☐Yes ☐No	Speech difficulty	☐Yes ☐No	Hoarseness
☐Yes ☐No	Personality Change	☐Yes ☐No	Seizures	☐Yes ☐No	Stiffness	☐Yes ☐No	Incontinence- bowel
☐Yes ☐No	Temper tantrums	☐Yes ☐No	Syncope	☐Yes ☐No	Trouble walking	☐Yes ☐No	Incontinence-bladder
☐Yes ☐No	Withdrawn behavior	☐Yes ☐No	Sleep problems	☐Yes ☐No	Weakness (arms)	☐Yes ☐No	Pain
☐Yes ☐No	Aggressive behavior	☐Yes ☐No	Blurred vision	☐Yes ☐No	Weakness (legs)	☐Yes ☐No	Abnormal movements
☐Yes ☐No	Inattention	☐Yes ☐No	Double vision	☐Yes ☐No	Tremor		
☐Yes ☐No	Hyperactive						
☐Yes ☐No	Impulsive						

Other Symptoms (please describe):

X

Parent/Guardian/Patient Signature **Date**

X

Physician Signature **Date**

Please return this questionnaire to pedsneurotele@med.cornell.edu prior to the doctor's visit.

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:
