HOUSTON AREA PEDIATRIC NEUROLOGY, PLLC
NEW PATIENT REGISTRATION FORM

Date of Visit: _____

Patient Information:

First and Last Name: _____ Date of birth: _____

Home Address: _____
City: _____ State: _____ Zip: _____

Parent Information:

First and Last Name: _____ Relationship to Patient: _____

Address (if different than above): _____
City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____ Work Phone: _____

e-mail: _____

Would you like to be contacted via phone, text or email: _____

Referring Physician: _____

Primary Care Physician (if different than above): _____Phone number: _____

Additional Physician's involved in patient's care: _____

Pharmacy Information:

Name of Pharmacy:_____ Phone:_____

Address: _____

History

Please provide as much information as possible to help us get to know you or your child better.

I. Reason for visit today: _____

_____

_____

Prior testing done: Please write approximate dates of when study was done and results if known. (When possible, please provide results of below studies or CDs with images.)

MRI/CT head: EEG:

Genetic testing: Other:

II. Medications

Please list medications the patient is **currently** taking, include dose and frequency taken (if known):

1. _____
2. _____
3. _____
4. _____

Please list medications the patient has taken in the **past**:

_____

***Drug Allergies:** _____

III. Medical History:

Has the patient been *hospitalized* in the past? Yes/No

Date: Reason for hospitalization:

Has the patient had *surgery* in the past? Yes/No

Date: Reason for surgery:

Are the patient's immunizations up to date? Yes/No

Birth History:

Was the patient born full term or premature? _____weeks

Birth weight: _____

Delivery: vaginal c-section

Complications or difficulties? _____

IV. Development:

sat up _____ crawled _____ walked _____ fed him/herself _____

first word _____ spoke in sentences _____ speech concerns? yes/no

Were developmental skills ever lost? Please explain: _____

Any concerns regarding sleep? Yes/No

_____

V. Family History: Please list any known diseases/disorders in family.

Mother: _____

Father: _____

Mother's parents: _____

Father's parents: _____

Siblings: _____

Aunts/Uncles: _____

VI. Social History:

Who does the patient live with? _____

Mother's age: _____ Occupation: _____

Father's age: _____ Occupation: _____

Names and ages of siblings:

_____

_____

Name of school patient attends: _____ Grade: _____

Concerns regarding school performance: _____

VII. Review of Systems:

Is the patient currently reporting any of the following symptoms? (circle all that apply)

NEUROLOGICAL	Headaches	Seizures	Weakness	Numbness
GENERAL	Fatigue	Fever	Recent illness	Dizziness
EYES	Vision change	Blurry vision	Vision loss	Eye pain
HEAD/EARS/THROAT	Congestion	Sore throat	Ringing in ears	Hearing loss
CARDIOVASCULAR	Chest pain	Palpitations	Syncope	Exercise intolerance
RESPIRATORY	Difficulty breathing	Wheezing	Cough	Snoring
GASTROINTESTINAL	Abdominal pain	Nausea	Vomiting	Constipation
SKIN	Rash	Moles/birthmarks	Skin Lesions	Nail changes
MUSCULOSKELETAL	Joint Pain	Joint Swelling	Back pain	Muscle pain
ENDOCRINE	Weight gain	Weight loss	Hair loss	Temperature intolerance
HEMATOLOGICAL	Easy bruising	Nose bleeds	Bleeding disorder	Anemia
PSYCHIATRIC	Depression	Sadness	Hallucinations	Anxiety

OTHER CONCERNS TODAY: _____

_____

_____