Oregon | Neurology Associates

**PATIENT DOB:** _____ / _____ / _____
MONTH DAY YEAR

**PATIENT NAME:** _____
LAST FIRST MI

## Patient Medical History: Please mark all that apply

| | | | |
|---|---|---|---|
| ○ Abnormal Heartbeat | ○ ADD/ADHD | ○ Anemia | ○ Problems with Anesthesia |
| ○ Anxiety/Panic Attacks | ○ Asthma | ○ Autism/Asperger's | ○ Autoimmune Disorders |
| ○ Bedwetting | ○ Bipolar Disorder | ○ Birth Defects | ○ Bleeding Disorder |
| ○ Blindness | ○ Blood Clots | ○ Cancer | ○ Cerebral Palsy |
| ○ Constipation/Encopresis | ○ Cystic Fibrosis | ○ Deafness | ○ Depression |
| ○ Diabetes | ○ Eczema | ○ Epilepsy/Seizure | ○ Fainting/Blackout |
| ○ Glaucoma | ○ Genetic Disorders | ○ Headache | ○ Hepatitis |
| ○ Heart Attack | ○ Heart Defect | ○ High Blood Pressure | ○ High Cholesterol |
| ○ HIV/AIDS | ○ IBS | ○ Kidney/Urinary Tract Disorders | ○ Learning Disability |
| ○ Mental Retardation | ○ Muscle Disease | ○ Neuropathy | ○ Nystagmus |
| ○ OCD | ○ Rheumatic Fever | ○ Schizophrenia | ○ SIDS/Crib Death |
| ○ Sleep Apnea | ○ Stomach/Digestion Disorders | ○ Sexually Transmitted Diseases | ○ Strabismus |
| ○ Tuberculosis | ○ Thyroid Disease | ○ Tic/Tourette Syndrome | ○ Tremor |
| ○ Other: | | | |

## Patient Surgical History: Please mark all that apply

| | | |
|---|---|---|
| ○ Carotid Endarterectomy | ○ Ileac/Femoral Bypass | ○ Brain Aneurysm |
| ○ Craniotomy | ○ Carpal Tunnel | ○ Cataract |
| ○ Cervical Spine | ○ Cholecystectomy | ○ CABG |
| ○ Heart Valve | ○ Hysterectomy | ○ Join Replacement |
| ○ Lumbar Spine | ○ Orthopedic | ○ Pacemaker/Defibrillator |
| ○ Coronary Stent | ○ Transplant | ○ Weight Loss |
| ○ Other Cancer: | ○ Other: | |

## Prior Neurodiagnostic Testing: Please mark all that apply

### MRI

- ○ Head
- ○ Neck
- ○ Lumbar
- ○ Other:

Date(s): _____

Testing Facility:

- ○ Oregon Imaging Center
- ○ Willamette Valley Imaging
- ○ Other:

### CT

- ○ Head
- ○ Neck
- ○ Lumbar
- ○ Other:

Date(s): _____

Testing Facility:

- ○ Sacred Heart Hospital
- ○ McKenzie-Willamette Hospital
- ○ Other:

### NCV/EMG

Date(s): _____

Testing Facility: _____

### EEG

Date(s): _____

Testing Facility:

- ○ Sacred Heart Hospital
- ○ McKenzie-Willamette Hospital
- ○ Other:

## Patient Birth History

Where was the child born?

○ Sacred Heart Hospital ○ McKenzie-Willamette Hospital ○ Other: _____

Birth Weight: _____ lbs. _____ oz.

Apgar Score: (please circle)

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 min: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| 5 min: | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

Problems During pregnancy with this child:

- ○ Diabetes
- ○ Fetal Distress
- ○ Premature labor
- ○ Bleeding
- ○ Hypertension
- ○ Other: _____
- ○ None

Problems during delivery of this child:

- ○ C-Section
- ○ Abnormal fetal heart rate
- ○ Vacuum extraction
- ○ Meconium staining
- ○ Premature rupture of membranes
- ○ Other: _____
- ○ None

## Developmental History

Did child develop at same age as siblings? (circle one) YES NO

At what age did the patient:

| | Lift head? | Roll over? | Sit without support? | Begin walking? | Say their first word? | Make their first sentence? | Pedal a tricycle? | Become toilet-trained? |
|---|---|---|---|---|---|---|---|---|
| **3 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **4 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **5 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **6 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **7 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **8 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **9 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **10 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **11 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **12 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **13 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **14 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **15 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **16 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **17 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **18 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **19 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **20 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **21 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **22 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **23 Months** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **2 Years** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **3 Years** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **4 Years** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **5 Years** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |
| **Unknown** | ○ | ○ | ○ | ○ | ○ | ○ | ○ | ○ |

## Social History

Family changes since symptoms began: (mark all that apply)

○ A new child ○ A marriage ○ A divorce ○ None

○ A job change ○ Serious illness ○ A death

School Name: _____ Grade Level: _____

Average Grades: (circle one) A's B's C's D's C's F's

Repeated a grade? (circle one) YES NO

## Social History

School days missed due to illness: (circle one) 0 1-5 6-10 10-20 > 20

How does child get along with others? (circle one) Not well As expected Very well

Discipline or behavior problems in school? (circle one) YES NO

Participates in sports: (circle one) YES NO

Child on IEP: (circle one) YES NO *If yes, for what*? _____

Drug use: (circle one) YES NO

*If yes, for how many years*? ○ Less than 1 ○ 1-2 ○ 3-4 ○ 5-6 ○ +7

Is there a history of physical and/or sexual abuse to the patient? (circle one) YES NO

Is the child adopted? (circle one) YES NO

Who has legal custody? (circle one)

Both parents Mom Dad Grandparents Court Other:

Patient writes with this hand: (circle one) RIGHT LEFT

## Gynecological History: Women only

Has patient begun menstruating? (circle one) YES NO

Age at menarche: _____

LMP: _____ /_____ /_____

Is patient on birth control? (circle one) YES NO

Has patient ever been pregnant? (circle one) YES NO

## Family History: (please mark all that apply)

| | Father | Mother | Sibling | Grandparent | Other | If other, please specify: |
|---|---|---|---|---|---|---|
| Abnormal Heartbeat | ○ | ○ | ○ | ○ | ○ | |
| ADD/ADHD | ○ | ○ | ○ | ○ | ○ | |
| Problems with Anesthesia | ○ | ○ | ○ | ○ | ○ | |
| Anxiety/Panic Attacks | ○ | ○ | ○ | ○ | ○ | |
| Autism/Asperger's | ○ | ○ | ○ | ○ | ○ | |
| Autoimmune Disorders | ○ | ○ | ○ | ○ | ○ | |
| Bipolar Disorder | ○ | ○ | ○ | ○ | ○ | |
| Birth Defects | ○ | ○ | ○ | ○ | ○ | |
| Bleeding Disorder | ○ | ○ | ○ | ○ | ○ | |

## Family History: (please mark all that apply)

| | Father | Mother | Sibling | Grandparent | Other | If other, please |
|---|---|---|---|---|---|---|

| | | | | | | specify: |
|---|---|---|---|---|---|---|
| Blindness | ○ | ○ | ○ | ○ | ○ | |
| Blood Clots | ○ | ○ | ○ | ○ | ○ | |
| Cancer | ○ | ○ | ○ | ○ | ○ | |
| Cerebral Palsy | ○ | ○ | ○ | ○ | ○ | |
| Deafness | ○ | ○ | ○ | ○ | ○ | |
| Depression | ○ | ○ | ○ | ○ | ○ | |
| Diabetes | ○ | ○ | ○ | ○ | ○ | |
| Epilepsy/Seizure | ○ | ○ | ○ | ○ | ○ | |
| Fainting/Blackout | ○ | ○ | ○ | ○ | ○ | |
| Glaucoma | ○ | ○ | ○ | ○ | ○ | |
| Genetic Disorders | ○ | ○ | ○ | ○ | ○ | |
| Headache | ○ | ○ | ○ | ○ | ○ | |
| Heart Attack | ○ | ○ | ○ | ○ | ○ | |
| Heart Defect | ○ | ○ | ○ | ○ | ○ | |
| High Blood Pressure | ○ | ○ | ○ | ○ | ○ | |
| High Cholesterol | ○ | ○ | ○ | ○ | ○ | |
| Learning Disability | ○ | ○ | ○ | ○ | ○ | |
| Mental Retardation | ○ | ○ | ○ | ○ | ○ | |
| Muscle Disease | ○ | ○ | ○ | ○ | ○ | |
| Neuropathy | ○ | ○ | ○ | ○ | ○ | |
| Nystagmus | ○ | ○ | ○ | ○ | ○ | |
| OCD | ○ | ○ | ○ | ○ | ○ | |
| Rheumatic Fever | ○ | ○ | ○ | ○ | ○ | |
| Schizophrenia | ○ | ○ | ○ | ○ | ○ | |
| SIDS/Crib Death | ○ | ○ | ○ | ○ | ○ | |
| Strabismus | ○ | ○ | ○ | ○ | ○ | |
| Thyroid Disease | ○ | ○ | ○ | ○ | ○ | |
| Tic/Tourette Syndrome | ○ | ○ | ○ | ○ | ○ | |
| Tremor | ○ | ○ | ○ | ○ | ○ | |

## Medications

Please list all prescription and over-the-counter medications you are taking at this time

| Name of Medication | Dosage/Strength | # Per Day |
|---|---|---|
| | | |
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| | | |
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| | | |

## Allergies

Please list all allergies (including environmental, medication, and food)

| |
|---|
| |
| |
| |

## Demographic Information:

**Preferred Language** ○ English ○ Spanish ○ Other:

**Ethnicity** ○ Hispanic or Latino ○ NOT Hispanic or Latino ○ Declined ○ Other:

**Race** ○ American Indian ○ Asian ○ Black or African American ○ Other:
○ Native Hawaiian ○ White ○ Declined