Romeo K. Fernandez, M.D., P.A.
Pediatric Neurology
7000 W Palmetto Park Road, Suite 307, Boca Raton, FL 33433
Telephone:(561) 288-5990 Fax: (954) 391-5008

Initial History Intake Form

Patient Name: _____ Date of Birth: _____ Appointment Date: _____

Reason for Visit

Please list all reasons for your visit with our office today:

Please describe the problem(s), including onset, symptoms, and duration: _____

_____

Current medications: _____

_____

Pregnancy, Birth, & Development

Patient is your child by: [ ]Birth [ ]Adoption [ ]Stepchild [ ]Other: _____

Place of birth: [ ]Home [ ]Hospital [ ]Other (*please specify*): _____

Delivery method: [ ]Vaginal [ ]Cesarean [ ]Unknown

Birth Weight: _____ Birth Length: _____ Patient born premature? If so, how many weeks? _____

Please list any medical problems that occured during pregnancy: _____

Please indicate any problems that occurred during the newborn period: _____

What age did your child: Sit alone: _____ Walk alone: _____ Say 1st words: _____ Toilet trained: _____

Immunizations

Is your child up-to-date with all immunizations, according to the CDC guidelines? [ ]Yes [ ]No

If no, please specify why: _____

For patients born outside the U.S.: Please list any other vaccinations your child has received:

_____

Allergies

Allergies to any medications? If yes, please list: _____

Other allergies: _____

Past Medical & Surgical History

Please list all of the patient's previous surgeries (including major and minor operations), any medical problems or diagnosed psychiatric disorders. Please also list any hospitalizations, broken bones, or severe sprains as well: _____

_____

Does the patient have a history of any concussions? [ ]Yes [ ]No

If yes, please specify the severity and date(s) of the injury: _____

Social History

Patient dexterity: [ ]Right-handed [ ]Left-handed [ ]Ambidextrous [ ]Unknown/ Not Applicable

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Patient Name: _____ Date of Birth: _____ Appointment Date: _____
Current (or upcoming) grade-level in school: _____ Are they in the grade-level with students of the same age group? [ ]Yes [ ]No

Concerns with patient's school performance?: _____

Concerns about the patient's relationships with teachers and other students?: _____

Does your child have a best friend? If so, for how long? _____

Extra-curricular activities your child participates in (sports, clubs, etc.): _____

Home & Family History

Who lives at home?

Name	Age	Relationship to Patient	Highest Education Level
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Parents of child: [ ]Married [ ]Unmarried [ ]Separated [ ]Divorced [ ]Other: _____

If divorced or separated, who is the legal guardian including medical decisions? _____

Parent's occupations: Mother: _____ Father: _____

Child's care (Please circle all that apply): Parents Relatives Babysitter Daycare

Specify hours per day for each: _____

Please circle any family history of the following:

Alcoholism/Drug Abuse	Heart Disease	Seizures	High Blood Pressure	Asthma
Cancer	Stroke	Thyroid Disease	Inherited/Genetic Diseases	Eczema
Kidney Disease	Psychiatric Disorders	Birth Defects	Bleeding/Clotting Disorders	Diabetes
Learning Disorders	Migraines	Demyelinating Disorder (MS)	Movement Disorders	Neuromuscular Disorders

Other: _____

Please indicate which family member has the condition, and for how long:

_____

_____

*I hereby attest that the information I provided on this form is factually correct and I did **not withhold** any information.*

Parent/Patient/Guardian Printed Name: _____

Parent/Patient/Guardian Signature: _____

Date: _____