PANDA Neurology

Review of Systems and Past History

Child's Name: _____ **DOB**: _____

Email (to receive receipts & statements): _____

Child's Current Medications and Dosage: **need refill?**

_____ _____

_____ _____

_____ _____

Drug Allergies: _____

Who is your child's PCP? _____

What pharmacy do you use? (Name/Address/Zip) _____

What laboratory are you required to use? ___ Lab Corp ___ Quest ___ Other _____

Has your child had any recent hospitalizations? _____ when/where? _____

Has your child had any recent labs or procedures? _____ when/where? _____

Review of Systems: Please indicate if your child has had any medical problems since the last visit, with approx. dates.

	Yes	No	Comments
Recent fever or weight loss	☐	☐	_____
Eye problems (cataracts, blindness, etc.)	☐	☐	_____
Ear, nose or throat problems	☐	☐	_____
Heart/Blood Pressure Problems/Blood Abnormalities	☐	☐	_____
Respiratory problems (asthma)	☐	☐	_____
Gastrointestinal/Stomach problems (vomiting, pain)	☐	☐	_____
Musculoskeletal Problems (joint or bone)	☐	☐	_____
Skin problems (rashes, acne, etc)	☐	☐	_____
Neurological problems (seizure, headache, stroke)	☐	☐	_____
Thyroid problems, Diabetes	☐	☐	_____
Allergies (Food, Seasonal)/Immunologic	☐	☐	_____
Psychiatric problems (behavior, depression, anxiety, etc)	☐	☐	_____
Sleep (trouble falling or staying asleep, snoring)	☐	☐	_____
Other not listed above (please explain)	☐	☐	_____

Parent Signature: _____ Date: _____

FOR OFFICE USE: Schedule Follow-up: when: _____ Provider: _____

Schedule Procedures (circle & attach order): Nerve Block / SPG Botox EMG EEG Therapy w/Leslie

Other: _____