NEUROMUSCULAR NEW PATIENT

(LABEL)
Family form Page 1
9/9/2011

What is the **reason** for the child's visit today?

____

Has any other specialist seen the child for this problem? □ No
□ Yes: ____________________________________

Please complete this form to the best of your knowledge.
Thank you.

BIRTH HISTORY

Yes	No	
□	□	Was the child adopted? If so, at what age:__________
□	□	Were fertility treatments required? ______________________
□	□	Were there any problems with the mother's health during pregnancy? (high blood pressure, diabetes, thyroid problems, illnesses, injuries, blood clots, etc)
□	□	Was the mother on any medications, smoke cigarettes, use drugs or drink alcohol during the pregnancy?
□	□	Were there any problems with the baby prior to birth? (placenta previa, placenta abrupta, abnormalities found on prenatal ultrasound, breech presentation, etc)
*	*	Was the child born full-term, premature or late? How many weeks? ________
□	□	Were there any problems with delivery? (decreased fetal heart rate, umbilical cord wrapped around the neck, etc)
□	□	Was the child born vaginally? If not, why? ______________________ How much did the child weigh? ____________
□	□	Were there concerns about the child after delivery? (taken to the special nursery, wasn't breathing or pink, etc)
□	□	Was the child discharged home in a regular amount of time? After how many days? __________

DEVELOPMENTAL HISTORY

Was the child **DELAYED** in his/her early development? □ Yes □ No

Age	Milestone	Age	Milestone	Age	Milestone
	Roll over		Babble		Smile
	Sit without support		First specific word		Feed self (finger feed)
	Stand alone		Followed 1 step commands		Wave "bye bye"
	Walk well		Combined words		Play pat-a-cake/peek-a-boo
	Kick a ball		Used prepositions		Drink from cup

Has there been developmental regression? □ Yes □ No

PAST MEDICAL HISTORY

Yes	No	
□	□	Has the child had any **MAJOR** illnesses or injuries? If yes, please describe: ______________________
□	□	Has the child been **HOSPITALIZED** overnight? If yes, please list reasons: ______________________
□	□	Has the child had **SURGERY**? If yes, please list with dates: ______________________
□	□	Are the child's **IMMUNIZATIONS** up-to-date?

FAMILY HISTORY (siblings, mother, father, maternal grandparent, paternal grandparent, aunts/uncles)

Yes	No		Yes	No		Yes	No	
□	□	Epilepsy/seizures	□	□	Psychiatric diagnosis	□	□	Heart disease
□	□	Headaches/Migraines	□	□	Muscle problems	□	□	Genetic disorder
□	□	Mental retardation	□	□	Autoimmune disorders	□	□	Multiple miscarriages
□	□	Developmental delays/ Learning differences	□	□	Tic disorder/Tourette Syndrome	□	□	Bleeding disorders/stroke

Please list any other significant **family medical history**: ______________________________

____

(CONTINUE NEXT PAGE PLEASE)

NEUROMUSCULAR NEW PATIENT

(LABEL)
Family form Page 2
9/9/11

Does the child have **OTHER** health problems?
If yes, please circle

Yes	No	
☐	☐	OVERALL: Chronic fever, failure to thrive, weight changes, chronic fatigue, other: ________________
☐	☐	HEAD: Eyes, vision (glasses / contacts), ears, hearing, nose, mouth, throat, frequent sinus infections, other: ______
☐	☐	HEART: Murmur, palpitations, irregular heart beat, fainting spells, congenital heart defects, other: _____
☐	☐	Cardiologist? Last visit:___________ ECHO: _____________ EKG:__________ Holter monitor: _____
☐	☐	LUNGS: Respiratory, breathing abnormalities, cough, pneumonia, asthma, other:__________________
☐	☐	Pulmonologist? Last visit:_________ PFT's: ___________ Sleep Study: __________ Trach_____ BiPAP ______ CPAP_______ CoughAssist ________ Vest _______
☐	☐	SLEEP: Sleep problems, daytime drowsiness, nighttime awakenings, apnea, night terrors, other: ______________
☐	☐	GI: G-tube, reflux, constipation, diarrhea, vomiting, abdominal pain, other:______________________________
☐	☐	Gastroenterologist? Last visit: _________ Swallow study: ___________
☐	☐	GU: Kidney, bladder, urinary, menstrual, other:____
☐	☐	MUSCULOSKELETAL: Joint or muscle pain, contractures, scoliosis, muscle weakness, other:______________
☐	☐	Orthopod? Last visit:__________ Spine X-ray:____________ DEXA scan:__________ Splints? ___________
☐	☐	SKIN: Skin breakdown, rash, eczema, birthmarks, other:____________________________________
☐	☐	ENDOCRINE: Diabetes, thyroid dysfunction, abnormal growth, other: ________________________
☐	☐	HEMATOLOGY: Anemia, sickle cell disease or trait, abnormal bleeding or clotting, other:___________
☐	☐	IMMUNE: Abnormal immunity, frequent illness, seasonal allergies, other:______________________
☐	☐	PSYCH/LEARNING: Attention deficit disorder, learning disability, Autism, depression, anxiety, other: _________
☐	☐	NEURO: Seizures, convulsions, migraines, headaches, delayed development, cerebral palsy, concussion, stroke, tics, meningitis, encephalitis, nerve injury, other: ______________________________
☐	☐	OTHER: Please describe: ____

Who lives at home with the child? ____

Where does the child go to school? ______________________________ **What grade**? ____________

Are there any concerns about the child's **academic performance** in school? ________________________

What kinds of **grades** does the child get? ____________________Does the child have an **IEP/504**? ☐ Yes ☐ No

If the child is too young to go to school, who cares for him/her during the day? ______________________

Does the child need **extra services** like physical therapy, occupational therapy or speech therapy? ☐ Yes ☐ No

Are there any recent changes at home (job changes, recent moves, new family members, new social stressors, etc)?

☐ No ☐ Yes: ____

When did your child's symptoms first start? ____

Are your child's physical symptoms getting better, worse, or staying the same? ______________________

What work-up has been performed thus far? ☐ I don't know

- ☐ CK:
- ☐ Lactate/pyruvate
- ☐ Serum AA
- ☐ Urine OA
- ☐ Other metabolic labs:
- ☐ MRI brain
- ☐ MRI spine
- ☐ MRS
- ☐ MRA
- ☐ EEG
- ☐ Lumbar Puncture
- ☐ EMG/NCS
- ☐ MUS
- ☐ Muscle biopsy

☐ Genetic testing: