UBNS Pediatric Neurosurgery - New Patient Evaluation
Oishei Children's Outpatient Center
Conventus Building • 1001 Main Street • 3rd Floor
Buffalo, NY 14203 • 716/218-1040

Child's Name: ______________________________

Date of Birth: ______/______/______

□ Imaging Today

□ Imaging at WCHOB
□ Imaging outside facility/downloaded
□ Imaging outside facility / no CD
□ Health Home

Child's Prenatal History

Any problems during pregnancy? ○Yes ○No
If yes, comment: ______________________________
Was the child born at full term? ○Yes ○No If no, how many weeks premature? _
Type of delivery: ○ Vaginal ○C-section
Any difficulties with the delivery? ○Yes ○No
If Yes, describe: ______________________________
Birth Weight: ____________________ ○ Unknown

Child's Early Development

Approximately when did the child first do the following:
Sat independently ________ Crawled ________ Walked ____________ Spoke first words ____________
Is the child in school? ○Yes ○No
If yes, which school? ______________________ Grade ________
How is the child's overall school performance? ○Above average ○Average ○Below average
Any concerns about school performance? ______________________________ ○ No Concerns

Child's Past Medical History

Has the child previously had any of the following? If yes, describe

Condition	Yes	No	If yes, describe
Neurological conditions	○Yes	○No	______
Birth defects/genetic disease	○Yes	○No	______
Allergies/Hay fever	○Yes	○No	______
Eye disease/glaucoma	○Yes	○No	______
Congenital hearing loss	○Yes	○No	______
Heart disease	○Yes	○No	______
High blood pressure	○Yes	○No	______
Diabetes	○Yes	○No	______
Lung disease/asthma	○Yes	○No	______
Gastrointestinal disease	○Yes	○No	______
Hepatitis/liver disease	○Yes	○No	______
Disorders of hormones	○Yes	○No	______
Kidney/bladder disease	○Yes	○No	______
Blood disease/anemia	○Yes	○No	______
Cancer	○Yes	○No	______
Arthritis/joint disease	○Yes	○No	______
Skin disease	○Yes	○No	______
Other conditions	○Yes	○No	______

Previous and Ongoing Medical Conditions (○ None)

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________

What other physicians are treating your child?

Physician: ______________ Phone: ____________ Reason: ______________
Physician: ______________ Phone: ____________ Reason: ______________
Physician: ______________ Phone: ____________ Reason: ______________

Current medications and doses: (○None) ______________________________
Any drug allergies? (○None) ______________________________
Any allergies to Latex (rubber)? ○Yes ○No
Are immunizations up to date? ○Yes ○No

Hospital Admissions and Operations (continue on back if necessary) (○ None)

Date	Condition	Operation (if performed)

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Name: ______________________________

Review of Systems

Has the child had any of the following symptoms? (underline any that apply) Please mark "None" if none.

General: Fever, weight loss, chills, excessive weight loss (❍ None)
Neurological: Headaches, neck or back pain, muscle weakness/paralysis, loss or change in sensation, difficulties speaking, slurred speech, facial weakness, swallowing difficulties, decrease in gait (walking) (❍ None)
Eyes: Abnormal vision, pain in eyes, wears eyeglasses, double vision (❍ None)
Ears: Earaches, ringing in ears, dizziness/vertigo, difficulties hearing (❍ None)
Nose/Throat: Persistent or recurrent sore throat or cough, nasal discharge, recurrent bloody nose (❍ None)
Heart: Chest pain, shortness of breath, palpitations/racing heartbeat, ankle swelling (❍ None)
Lung: Chest pain, shortness of breath, cough, coughing up blood (❍ None)
Gastrointestinal: Loss of appetite, nausea, vomiting, vomiting blood, diarrhea, blood in stool, black tarry stools, abdominal pain (❍ None)
Bladder/Kidney: Pain when urinating, difficulty urinating, urinary accidents, blood in urine, kidney infections, kidney stones (❍ None)
Musculoskeletal: Joint pain, joint swelling, joint deformity, muscle pain, muscle weakness, scoliosis or back deformity (❍ None)
Endocrine/Hormone: Hot or cold intolerance, early signs of puberty, delayed puberty, abnormal menstruation (❍ None)
Hematologic: Swollen lymph glands, anemia, easy bruising or bleeding (❍ None)

Family History

Has anybody in the child's family had the following? If yes, describe relationship to child and describe

Neurological conditions ❍Yes ❍No ______________________________
Birth defects/genetic disease ❍Yes ❍No ______________________________
Allergies/Hay fever ❍Yes ❍No ______________________________
Eye disease/glaucoma ❍Yes ❍No ______________________________
Congenital hearing loss ❍Yes ❍No ______________________________
Heart disease ❍Yes ❍No ______________________________
High blood pressure ❍Yes ❍No ______________________________
Diabetes ❍Yes ❍No ______________________________
Lung disease/asthma ❍Yes ❍No ______________________________
Gastrointestinal disease ❍Yes ❍No ______________________________
Hepatitis/liver disease ❍Yes ❍No ______________________________
Disorders of hormones ❍Yes ❍No ______________________________
Kidney/bladder disease ❍Yes ❍No ______________________________
Blood disease/anemia ❍Yes ❍No ______________________________
Cancer ❍Yes ❍No ______________________________
Arthritis/joint disease ❍Yes ❍No ______________________________
Skin disease ❍Yes ❍No ______________________________

Social History

Child lives with: ❍Mother and Father ❍Mother ❍Father Other ____________
Parent's marital status: ❍Married ❍Single ❍Divorced ❍Widowed
Legal custody (if parents not married) ______________________________

Siblings: Name Gender Age
❍ None
1) ______________________________
2) ______________________________
3) ______________________________

Parent Names: ____________________ ____________________
(Print name) (Relationship)

____________________ ____________________
(Print name) (Relationship)

Any household pets? ❍Yes ❍No List: ______________________________

If your child is 13 yrs or older:

Does he/she smoke now? ❍Yes ❍No If yes, how packs per day? _____ For how many years? _____
Is he/she a former smoker? ❍Yes ❍No If a former smoker, when did he/she quit? _____

For Office Use Only

I verify that I have reviewed this document and its contents:

Physician Signature ______________________________ Date ______________

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