Granger Medical Clinic Parkway
1288 West 12700 South
Riverton, UT 84065
801.432.3000

PEDIATRIC NEUROLOGY NEW PATIENT VISIT FORM

Date: ______________________

General Information:

Patient Name: ____

Date of Birth: ____________________________ Age: ____________________________

Primary Care Provider: ____

Pharmacy: ____

Patient's Medical History:

Circle one: *left-handed* *right handed* *ambidextrous* *can't tell*

Current medications, vitamins and supplements: ☐ **None**

Name *Dose (mg)* *# of times per day*

____

____

____

Birth History:

_______term if not term, # of weeks early:__________ Birth weight:________________

Location (name of Hospital or center, home, etc.): ____

Were there any problems during pregnancy, labor or delivery? ☐ **None**
If problems, please describe:

____

____

Current and Past Medical Problems: ☐ **None**

____

____

____

Allergies: ☐ **None**

Drug *Reaction*

____

____

____

*****PLEASE FILL OUT BOTH SIDES*****

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Surgeries: ☐ **None**

Date (month/year) *Surgery*

___

___

___

Hospitalizations: ☐ **None**

Date (month/year) *Reason*

___

___

___

Family History (list anyone who has seizures, strokes, cerebral palsy, headaches, etc.):

___

___

___

Social History

Who lives at home? ___

Patient's School & Grade: ___

_______Has an IEP _______ Has a 504

Tobacco use or exposure? ☐ **None** If yes, please describe:___

Circle any other Current Problems:

Fatigue	Chest palpitations	Rash
Problems sleeping	Constipation	Anxiety
Decreased hearing	Diarrhea	Depression
Ringing in the ears	Nausea/vomiting	Learning problems
Weight loss	Choking	Stress at school
Weight gain	Abdominal pain	Stress at home
Breathing problems	Muscle aches or cramps	
Chest pain	Weakness	

Please provide any other details you would like:

___

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*****PLEASE FILL OUT BOTH SIDES*****