AZ NeuroRecovery Treatment Innovation Center (A. N. T. I. C.)

Healing all of you!

Not just *part* of you…

Patient Name: _____ Date of Visit: _____

DOB: _____

BIRTH HISTORY

Gestation: ☐ Full Term ☐ Pre-Term, _____ weeks ☐ Post-Term, _____ weeks

Delivery: ☐ Normal, spontaneous, vaginal ☐ Assisted vaginal (forceps/suction)

☐ Normal, induced, vaginal ☐ Caesarean (emergency/elective)

☐ VBAC

Number: ☐ Single ☐ Twin (identical/fraternal) ☐ More than 2, _____ (number)

Pregnancy: ☐ Normal ☐ In vitro fertilization ☐ Surrogate

Complications: _____

_____

_____

_____

DEVELOPMENTAL HISTORY

☐ Normal

☐ Delayed, please specify: _____

_____

_____

_____

FAMILY HISTORY

☐ Epilepsy _____

☐ Seizure/convulsions _____

☐ Headache/migraine _____

☐ Sleep disorders/narcolepsy _____

☐ Multiple sclerosis _____

☐ Other neuro dso _____

☐ Stroke _____

☐ Heart disease _____

☐ High blood pressure _____

☐ Asthma _____

☐ Respiratory dso _____

☐ Irritable Bowel Syndrome _____

☐ Gastrointestinal dso _____

☐ Kidney disease _____

☐ Thyroid disease _____

☐ Diabetes mellitus _____

☐ Other endocrine dso _____

☐ Allergy/Hay fever _____

☐ Autoimmune dso _____

☐ Bleeding/clotting dso _____

☐ Other _____

_____

SOCIAL HISTORY

Parents: _____

Parents' Occupation: _____

Siblings (include age, sex and health status): _____

_____

_____

_____

_____

Current Educational Level: _____

Previous Neurocognitive Evaluation: ☐ No ☐ Yes, when? _____

IEP: _____

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PAST MEDICAL HISTORY:

- ☐ Neurologic Disorder _____
- ☐ ENT Disorder _____
- ☐ Cardiovascular Disorder _____
- ☐ Respiratory Disorder _____
- ☐ Gastrointestinal Disorder _____
- ☐ Endocrine Disorder _____
- ☐ Musculoskeletal Disorder _____
- ☐ Hematologic Disorder _____
- ☐ Immunologic Disorder _____
- ☐ Other _____

PAST HOSPITAL ADMISSIONS: _____

_____

_____

_____

_____

PAST SURGERIES: _____

_____

_____

_____

_____

MEDICATION LIST (include dose and schedule):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

ALLERGIES: ☐ No known drug allergies

☐ _____

_____

_____

OTHER (cigarette, recreational drug, alcohol use): _____

_____

_____

_____

_____

REVIEW OF SYSTEMS (circle if present; circle NONE if negative)
GEN: fever, chills, wt. loss, wt. gain, fatigue, appetite change, NONE
EYE: blurry vision, double vision, eye pain, NONE
ENT: hearing change, ringing ear, hoarseness, diff swallowing, NONE
CV: chest pain, palpitations, racing heartbeat, NONE
RESP: shortness of breath, cough, wheezing, NONE
GI: nausea, vomiting, abd pain, diarrhea, constipation, bloody stool, NONE
GU: dysuria, frequency, urgency, incontinence, bloody urine, NONE
MUSC/SKEL: muscle pain, joint pain, NONE
SKIN: rash, redness, abn pigmentation, NONE
NEURO: headache, dizziness, numbness, weakness, tremors, memory, NONE
PSYCH: mood changes, anxiety, hallucinations, sleep disturbance, NONE
ENDOCRINE: excessive sweating, abnormal periods, abnormal growth, NONE
HEM/ONC: swollen lymph nodes, easy bruising, pallor, NONE
ALL/IMM: frequent infections, NONE
☐ All other system review are negative

PHARMACY NAME: _____

ADDRESS (or cross streets): _____

PHONE: _____