MIDWEST NEUROSURGERY & SPINE
Adult & Pediatric SPECIALISTS

COMPLETE BOTH PAGES
BLACK INK ONLY

Checked-in: _____ *Updated*: _____

Patient Name: _____ Sex: M / F
(First) (MI) (Last)

Address: _____
(Street) (City) (State) (Zip)

Age: ____ D/O/B: _____ Social Security #: _____

Guarantor Information (person financially responsible for patient):

Name: _____ D/O/B: _____

Address: _____

Social Security #: _____ Relationship to Patient: _____ Marital Status: __

PHONE: Home: _____ Work: _____ Cell: _____

Employer: _____

Employer Address: _____

Insured's Name (if different than above): _____ D/O/B:_____

Relationship to Patient: _____ Social Security #: _____

Insured's Employer: _____ Phone #: _____

Emergency Contact (person not living with you we may contact in case of emergency):

Name: _____ Relationship: _____

Phone #s: _____

Referring Physician: _____

Family Physician: _____

Alternate Parent Information:

Name: _____ D/O/B: _____

Address: _____ Social Security #: _____

PHONE: Home: _____ Work: _____ Cell: _____

Employer: _____ Employer Address: _____

_____

Insurance:

Primary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

Secondary Insurance: _____ Policy Holder: _____

Policy #: _____ Group #: _____

_____

Auto Insurance (if due to an accident):

Policy Holder: _____ Claim #: _____

Company: _____ Phone #: _____

Address: _____

Date of Accident:_____ Person handling claim: _____

_____

Do you have an attorney or legal action current or pending for the condition for which you are seeking legal consultation?

If yes - Name of Attorney: _____

Address: _____ Phone #: _____

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COMPLETE ALL FOUR PAGES
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Checked-in: _____ *Updated*: _____

Patient Name: _____ **D/O/B:** _____

Height: _____ **Weight:** _____ **Birth Weight:** _____

Reason for today's visit:_____

Complications with pregnancy/delivery:

Was the baby born prematurely? ☐ No ☐ Yes – how early? _____

Did the baby stay in intensive care? ☐ No ☐ Yes – how long? _____

Was the baby on a ventilator ☐ No ☐ Yes – how long? _____

Did the baby have any bleeding in the brain? ☐ No ☐ Yes

Any birth trauma: Skull Fracture / Cephalohematoma / Brachioplexus Nerve Injury

At what age did your child start walking? _____

Is your child "potty" trained? ☐ No ☐ Yes – age: _____

Does your child have any of the following?

☐ Hydrocephalus ☐ Abnormal Head Shape – ☐ Big / ☐ Small

☐ Genetic disorders/syndromes: _____

_____

Additional ***chronic health problems***: _____

_____

Other specialists who care for your child: _____

_____

Past Surgeries/Hospitalizations	Date	Complications

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Patient Name: _____

Current Medication(s)	Dose	Frequency

Allergies to Medications: ☐ **None**

Medication	Reaction

Allergy to Latex: ☐ **No** ☐ **Yes**

Diet: ___ Normal for age ___ by mouth ___ by tube

_____

Family History: *Please circle those conditions present in siblings, parents and grandparents*

☐ High Blood Pressure ☐ Bleeding Problems ☐ Heart Disease ☐ Cancer
☐ Liver Disease ☐ Birth Defects ☐ Kidney Disease ☐ Diabetes

If yes, explain _____

_____

_____

Have you been told your child has any delays in developing skills**?** ☐ No ☐ Yes

☐ **Motor** ☐ **Speech/Language** ☐ **Social**

If yes, explain: _____

_____

Patient Name: _____

Review of Systems: (conditions or symptoms your child has currently OR had in the past)

Constitutional		
Unexplained fever **(recent)**	Yes	No
Weight loss	Yes	No
Eyes		
Eyes crossing	Yes	No
Vision loss	Yes	No
Ear, Nose, Throat & Mouth		
Hearing loss	Yes	No
Difficulty swallowing	Yes	No
Difficulty chewing	Yes	No
Choking	Yes	No
Cardiovascular		
Heart abnormality or defect	Yes	No
Respiratory		
Turning blue	Yes	No
Mechanical ventilation – history of / currently use	Yes	No
Tracheostomy – history of / currently use	Yes	No
BPD	Yes	No
Integumentary		
Birthmarks	Yes	No
Sacral or other spinal dimple	Yes	No
Endocrine		
Growth problems	Yes	No
Excessive thirst or urination	Yes	No
Gastrointestinal		
Chronic abdominal pain	Yes	No
Constipation	Yes	No

Patient Name: _____

Review of Systems: (conditions or symptoms your child has currently OR had in the past)

Genitourinary

Kidney or urinary infections	Yes	No
Urethral straight catheterization (non-balloon)	Yes	No

Musculoskeletal

Trouble using arms	Yes	No
Trouble using legs	Yes	No
Scoliosis	Yes	No

Neurological

Headaches	Yes	No
Dizziness	Yes	No
Seizures	Yes	No

Hematologic/Lymphatic

Bleeding Tendencies/Hemophilia/Clotting disorder	Yes	No
Anemia	Yes	No

Form completed by: _____ Date: _____

Relationship to child: _____