Yuri Brosgol, M.D.
Diplomate in Child Neurology *Certified By A.B.P.N*

Patient's Last Name . . . . . First Name . . . . . .

Age: . . . . . Date of Birth: . . . / . . . / . . .
Month Day Year

Referred By: . . . . . **Date: … / . . . / . . .**

Child's Birth, Developmental, Medical History (Attention Mothers!)

What was the term of pregnancy?	_ 38-42 weeks _ 34-37 weeks _ … weeks	
Did you have any illnesses during pregnancy?	_Diabetes _Hypertension _ Fever _ ….	
Did you take any medications while pregnant or before labor?	_No _ …	
What kind of delivery did you have?	_Normal Vaginal _Stimulated _Forceps _C-section _ …	
Baby's **Birth Weight** was ……	Born in which Hospital? ….	
How did the baby do right after birth?	_ OK, discharged home on the … day. _ Jaundice _ …	
Any problems during first 1-3 months?	_ No _Extreme colic _ Extreme irritability _Poor feeding _ Inactivity _ Formula Intolerance _ …	
Is the child on any medications?	_ No _ …	**Allergies:** _No _…
Did the child have any…	_ Tick bites _Head injuries _ Loss of consciousness _Hospital admissions	
Do you have history of previous miscarriages?	_ No _ Yes…	
Do you have other children?	_ No _ Yes: …_ …_ from this marriage ; …_ … _ from previous	
Anybody in the family known with …	_Seizures _Tics _ADHD/delays _Early hearing loss _Married as cousins	
When did the child first sat alone?	_4-6 mo _ 6-8 mo _ 8-10 mo _ …	
When did the child first walk alone?	_8-10 mo _10-11 mo _around 12 mo _14 mo _ …	
The child is **_right _left** handed …	_ after 1 year of age _before 1 y.o. _Still no hand preference	
Did **(_ does still)** the child have problems	_running _pedaling _climbing _descending stairs _frequent tripping _frequent falling _bumping into things _balancing ? **_No Problems**	
Did **(_ does still)** the child have problems	_ buttoning/snapping _tying shoe-laces _writing _being very clumsy **_No Problems**	
Did **(_ does still)** the child have problems	_ Temper tantrums _Separation from parents _Excessive fears	
Did **(_ does still)** the child have problems	_Bedwetting (When toilet trained? ….) _Sleep walking _Sleep talking	
Does the child SNORE loudly at night?	_ No _ Yes	
Does the child PICK and eats inedible things (paint chips, ground, etc.) ?	_ No _ Yes	
Does the child JERK his legs more than 20 times during night sleep?	_ No _ Yes	