Department of Neurology: First-Visit Questionnaire

Date: 20___ / ___ / ___

Patient Name: _____ Male / Female Date of Birth: 20___ / ___ / ___
Parent/Guardian Name: _____ Form Completed by: _____

1. Main Complaint

What is the primary reason for your visit today? Please describe when and how the symptoms started, their progression, and frequency.

2. Prenatal History (Conditions during pregnancy)

- **Risk of miscarriage (bleeding, pain, etc.):** No / Yes (Around month ____ of pregnancy)
- **Maternal illness, fever, or infection:** No / Yes (Details: _____)
- **Gestational hypertension (toxemia) or proteinuria:** No / Yes
- **Medications taken or X-ray examinations:** No / Yes (Details: _____)
- **Fetal movement:** Started around month ____. Intensity: (Strong / Normal / Weak)
- **Other concerns:** _____

3. Birth and Neonatal History

- **Gestational age at birth:** ____ weeks ____ days (If unknown: Early / On time / Late)
- **Measurements at birth:** Height_____cm / Weight_____g / Head circumference_____cm
- **Delivery complications (Check all that apply):** C-section / Forceps or Vacuum / Breech / Cord around neck / Asphyxia (did not cry immediately)
- **Neonatal issues:** Seizures: No / Yes Severe jaundice: No / Yes Incubator use: No / Yes (Duration: ____ days)
  Respiratory distress: No / Yes

4. Developmental Milestones

- **Neck control (holding head up):** Around ____ months **Rolling over:** Around ____ months
- **Sitting alone:** Around ____ months **Crawling:** Around ____ months
- **Pulling up to stand:** Around ____ months **Walking alone:** ____ years ____ months
- **Meaningful words:** ____ years ____ months **Two-word sentences:** ____ years ____ months

5. Seizures and Spells

History of seizures/spells: No / Yes (If yes, please provide details below)

- **First episode:** ____ years ____ months old (Fever: No / Yes: ____ °C)
- **Appearance:** (Stiffening / Twitching / Staring / Other: _____)
- **Duration:** Approx. ____ min ____ sec **Most recent episode:** Around (Year/Month/Day): ____ / ____ / ____

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6. Family History

Relationship (List siblings in age order)	Current Age / Age at Death	Gender (Circle one))	Medical conditions or symptoms	Occupation / School / Education
Father		M		
Mother		F		
☐ Patient / ☐ Sibling		M / F		
☐ Patient / ☐ Sibling		M / F		
☐ Patient / ☐ Sibling		M / F		
☐ Patient / ☐ Sibling		M / F		
☐ Patient / ☐ Sibling		M / F		
Paternal Grandparents	/			
Maternal Grandparents	/			

- **Relatives with similar symptoms or neurological diseases:**
  - No / Yes (Relationship: _____ Diagnosis/Symptoms: _____)

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7. Personality, Schooling, and Daily Life

Please describe any issues noted during infant health checkups (development, language, hearing, etc.), current behavior at school or home, or any concerning habits.

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8. Past Medical History and Allergies

- **Pre-existing conditions or surgery:** No / Yes (Details: _____)
- **Current medications:** No / Yes (Details: _____)
- **Allergies:** No / Yes (Details: _____)