Pediatric Neuro-ophthalmology
Telephone (212) 305-5400
Facsimile (917) 677-7172
Electronic mail sakanemd@gmail.com

Steven A. Kane, M.D., Ph.D.
635 West 165th Street, Room 102
New York, NY 10032

Patient name _____ **Today's date** _____

Please complete all fields on these pages. **Please write clearly.**

What is the reason for today's visit? for example, *"left eye crossing for two months, etc."*

_____

_____

Patient's age _____ **School grade** _____

Date of birth _____ **Sex (circle one) Male / Female**

CONTACT INFORMATION

Parent Names M _____ **F** _____

Parent Occupation M _____ **F** _____

Street Address/Apt. _____

City, State Zip _____

E-mail M _____ **F** _____

Home/work telephone _____

Cellular phone M_____ **F**_____

HEALTH PLAN INFORMATION

Health plan name _____

Policy Number (of patient) _____

Name of policy guarantor _____

Guarantor date of birth/Soc. Sec. # _____

Referral required? (circle one) Y / N Deductible/coinsurance? Y / N

Co-payment required? (circle one) Y / N Amount due? $_____

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REFERRING DOCTOR CONTACT INFORMATION

Name	
Street address (include office/suite #)	
Street address	
City, State Zip	
Telephone	
Facsimile	
E-mail	

PEDIATRICIAN CONTACT INFORMATION

Name	
Street address (include office/suite #)	
Street address	
City, State Zip	
Telephone	
Facsimile	
E-mail	

Pharmacy _____

Pharmacy telephone/fax # _____

Feel free to list the names and contact information any other physicians involved in your child's or your care if you want a copy of the initial consultation report sent to them.

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REVIEW OF SYSTEMS

(Place a check mark in the 'Normal' column if patient has no symptoms related to that system. If patient has symptoms related to that system underline, circle, or add any symptoms that are present and add comments in 'Findings')

Normal	System	Symptoms	Findings
	Constitutional	Fever, weight loss, fatigue, recurrent infection, unusual odors of body fluids	
	Eyes	Double vision, loss of visual acuity, blurring, cataracts, strabismus, need for glasses	
	Ears, nose and throat	Hearing loss, ringing in the ears, vertigo, ear discharge, infections, congestion, hoarse voice, difficulty swallowing, dental problems	
	Respiratory	Shortness of breath, wheeze, cough, coughing up blood, blue discoloration, altered pattern of breathing	
	Cardiovascular	Chest pain, abnormal rate or rhythm, abnormal blood pressure, shortness of breath, swelling of ankles	
	Gastrointestinal	Diarrhea, constipation, nausea, vomiting, rectal bleeding, black tarry stool, weight loss or gain, jaundice, specific food intolerance or aversion	
	Genitourinary	Blood in the urine, pain on urination, loin pain, impotence	
	Integumentary	Dark or light patches on the skin, rash, changes in hair or nails	
	Musculoskeletal	Joint pain or swelling, small lumps under the skin, skeletal deformities	
	Psychiatric	Mood changes, delusions, hallucinations	
	Endocrine	Thyroid, adrenal, diabetes, parathyroid disease, growth insufficiency	
	Hematological and lymphatic	Pale appearance, loss of energy, enlargement of lymph nodes, abnormal bleeding or clotting	
	Allergic	Runny nose, tearing, red eyes, skin redness or swelling	
	Neurological	Abnormalities of higher function (including speech and language), strength, coordination, sensation, development; seizures or other spells; headaches	

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CHARACTERISTICS OF PREGNANCY

Length of Pregnancy (weeks) _____

Length of labor _____

Delivery method (vaginal, vacuum extraction, forceps, Caesarian section) _____

Place of delivery _____

Birth weight _____ **Apgar scores** _____

Resuscitation needed? (circle one) *Y / N* ***If yes, explain*** _____

Abnormalities noted at birth? (circle one) *Y / N* ***If yes, explain*** _____

Jaundice? (circle one) *Y / N* ***If yes, explain*** _____

Intensive care? (circle one) *Y / N* ***If yes, explain*** _____

Other problems? (circle one) *Y / N* ***If yes, explain*** _____

MOTHER'S HEALTH DURING PREGNANCY (circle one) *good / problematic*

If problematic, explain _____

Folic acid before conception? (circle one) *Y / N* ***antenatal vitamins and iron?*** **(circle one)** *Y / N*

Exposure to radiation; surgery or treatment? (circle one) *Y / N* ***If yes, explain*** _____

Infections? (circle one) *Y / N* ***If yes, explain*** _____

Prescribed medications? (circle one) *Y / N* ***If yes, explain*** _____

Alcohol, tobacco,drugs? (circle one) *Y / N* ***If yes, explain*** _____

Diabetes before or during pregnancy? (circle one) *Y / N* **High blood pressure? (circle one)** *Y / N*

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DEVELOPMENTAL MILESTONES

(Please check 'normal' if patient attained the milestones in the age range indicated, otherwise record the time the milestone was attained with any comments)

Milestone [usual age range for term infants]	**Normal**	**Time achieved otherwise/comments**
Regards (looks at) toy [newborn]		
Turns to sound [0-2 months]		
Holds toy [1-2 months]		
Tries to repeat sounds, coos, blows bubbles [2-4 months]		
Holds object with both hands [4-5 months]		
Transfers object from hand to hand [5 –6 months]		
Knows own name, babbles – 'ba, ma, ga' [5-7 months]		
Reaches with one hand [4-7 months]		
Pincer grasp [7-12 months]		
Sits alone at least 10-30 seconds [5-8 months]		
Stands holding furniture [6-12 months]		
Points to nose on request, says 'mama, dada', repeats sounds and words [8-12 months]		
Stands alone [9-16 months]		
Walks alone [9-17 months]		
Walks upstairs with help [12-23 months]		
Identifies familiar objects, uses 10-50 words [13-20 months]		
Jumps off floor with both feet [17-30+ months]		
Walks up stairs alone, both feet on each step [19-30+ months]		
Understands simple questions, uses 50-75 words, 2 word sentences, stutters [18-24 months]		
Pedals tricycle, runs smoothly [4 years]		
Walks downstairs, catches bounced ball, jumps on one foot [5-6 years]		
Pedals bicycle [7 years]		

SCHOOL PERFORMANCE (current and past marks earned, areas of strength and weakness)

_____

BEHAVIOR (describe any concerns)

_____

SOCIAL HISTORY (Who does the patient live with? Describe your family's circumstances, individuals living in the household, and their relationships to the patient and to each other.)

_____

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MAJOR ILLNESSES/HOSPITALIZATIONS/INJURIES/SURGERIES

Date/age	Illness/injury/surgery	Treating physician/hospital

DRUG THERAPY (PAST AND PRESENT) (list all prescribed medications including dose and times. Also list all vitamin, herbal and dietary supplements and other substances including caffeine and alcohol)

Name	Dose	Started	Ended (note if current)

IMMUNIZATIONS (if all given without problems, circle '**Up-to-date**', otherwise please specify immunizations given and any problems encountered or those missing and why) _____

ANY ALLERGIES TO MEDICINES? (list name of medicine and describe the reaction; circle '**None**' if there is no history of such an event)

Name of drug or allergen	Effect (*e.g. rash, asthma*)	Date of event(s)

FAMILY HISTORY OF ILLNESSES, DISEASES, NEUROLOGICAL OR BEHAVIORAL ISSUES? (Include all relatives, including deceased relative, with date and cause of death)

Relationship	Name(s)	Age(s)	Illnesses
Brothers and sisters			
Mother			
Father			
Mother's father			
Mother's mother			
Father's father			
Father's mother			
Other relatives			

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NOTICE OF PRIVACY PRACTICES

Acknowledgment of receipt

I acknowledge that I was offered (or by request, was provided) with a copy of the New York Presbyterian/Columbia University Medical Center notice of privacy practice.

Print patient's name (and parent or guardian's name, if applicable)

_____

Please sign below (if underage, patient's parent or legal guardian please sign)

Patient's (or legal guardian's) signature _____ **Date** _____

I verify the accuracy of the information on these pages. I authorize Dr. Kane to share any and all records pertaining to my child's or my healthcare with other involved healthcare providers for the purposes of enhancing and coordinating care.

Patient's (or legal guardian's) signature _____