NEUROMUSCULAR FOLLOW-UP

(LABEL)

Date: Age: days / weeks / months / years
Accompanied by: mother / father / MGM / PGM / other family member / foster care / nurse / social worker
Gender: male / female
Handedness: left / right / ambidextrous / N/A

Please help us by filling out this form. Thank you!

What is the reason for today's visit?_____
□ scheduled follow-up □ sick visit □ new problem:
_____
I would like today's information sent to: □ Me □ My Doctor
And also: _____

Since your last visit, has the patient had (please give dates):
□ Holter monitor □ EKG □ Echocardiogram
□ Sleep study □ PFTs □ Swallow study
□ Dexa Scan □ Spine X-Ray □ Other:

Since the last visit, has the patient seen a (please give dates):
□ Cardiologist □ Endocrinologist
□ Gastroentrologist □ Ophthalmologist
□ Orthopedist □ Pulmonologist

Since the last visit, has the patient had surgery (please give dates):
□ Muscle biopsy □ Tendon Release
□ Tonsillectomy/Adenoidectomy □ Spinal Fusion
□ Tracheostomy placed □ Other

Since the last visit, has the patient been hospitalized?
□ No □ Scheduled admission Reason: _____ □ Emergency Reason: _____

Has the patient stopped any medications since the last visit? □ No □ Yes (please list):
_____

Are immunizations up-to-date? □ yes □ no

Does the patient have other health problems?

Yes	No	
□	□	Chronic fever, weight changes, headaches
□	□	Eyes, vision, ears, hearing, nose, mouth, throat, sinus
□	□	Respiratory, breathing, cough, pneumonia
□	□	Use of CPAP or BIPAP
□	□	Morning headaches, daytime drowsiness, nighttime awakenings, apnea
□	□	Heart murmur, palpitations, irregular heart beat, fainting spells
□	□	Reflux, constipation, vomiting, abdominal pain
□	□	G-tube or NG tube? Type of formula:_____
□	□	Kidney, bladder, urinary or menstrual
□	□	Skin breakdown or rash
□	□	Seizures, delayed development
□	□	Attention deficit disorder, Learning Disability, Autism
□	□	Depression, anxiety
□	□	Diabetes, hypothyroid, hyperthyroid, delayed puberty, early puberty, short-stature
□	□	Anemia, sickle cell, abnormal bleeding
□	□	Cancer, leukemia
□	□	Allergies, abnormal immunity
□	□	Change in activity level

Any **NEW family** Neuromuscular problems since last visit?
□ New diagnosis
□
□
□
□ other _____

Has carrier testing been performed on the parents? □ No □ Yes

Since the last visit, have there been any problems managing your child's healthcare needs? □ No □ Yes

Patient lives with: mom / dad / step-parent / grand parent(s) / other family / foster care / court
And how many siblings? _____

Home assessment:
□ single story □ 2 or more stories
□ steps into the home: _____ □ steps inside the home: _____
□ ramp / stair glide □ hand rails on the steps
□ own □ rent
In the bathroom that the patient uses, is there:
□ bathtub □ shower
□ grab bars □ raised toilet
School assessment:
□ School grade _____ □ Grades: A / B / C / D / F
□ IEP: yes / no □ 504 plan: yes / no
□ Plans for future:

□ Employed as a:

What therapies does the patient receive & how often:
□ PT_____ □ OT _____
□ Speech _____ □ Dev. Teacher _____
□ Other _____
Are the therapies performed: □ in school? □ at home? □ outpatient?

Does the patient use:
□ manual wheelchair/ stroller □ stair lift
□ power wheelchair / scooter □ walker- type: _____
□ adapted van □ hoyer lift
□ bath chair/commode □ hospital bed
□ Cough Assist □ CPAP / BiPAP
□ Vest □ ventilator
□ day splints (hands / feet) □ night splints (hands / feet)
□ adaptive equipment □ other: _____

Does the patient need help with:
□ rolling in bed □ transfers
□ balance or walking □ dressing
□ climbing stairs □ eating / feeding self

☐ ☐ Change in your family or home routine ☐ ☐ Joint or muscle pain ☐ ☐ Joint contractures	