NEUROLOGY ASSOCIATES - NEW PATIENT HISTORY FORM

Today's Date: _____

Name:_____ Date of Birth: _____ Age:_____

Referring Physician: _____ Family Physician: _____

What is the reason for this consultation: _____

_____

Height:_____ Weight:_____ Are you Right handed _____ Left handed: _____

PAST MEDICAL HISTORY: (please list all of your medical conditions)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PAST SURGICAL HISTORY: (please list all major surgeries)

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATIONS:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

DRUG ALLERGIES: _____

SOCIAL HISTORY:

Occupation: _____

Marital Status: Single Married Divorced Widowed

Children: Yes No How many? _____

Education: High School College Graduate School

Tobacco Use: Yes No How much? _____

Alcohol Use: Yes No How much? _____

Caffeinated Beverages per day _____

Planning Pregnancy? Yes No N/A

FAMILY HISTORY: (circle all that have occurred and in which blood relative)

Migraine _____

Stroke _____

Seizures _____

Multiple Sclerosis _____

Alzheimer's Disease _____

Parkinson's Disease _____

Neuropathy _____

Muscle Disease _____

Tremor _____

Review of Systems: Please indicate any personal history below:

- ***CONSTITUTIONAL SYMPTOMS***
  - Good general health lately..... No Yes
  - Recent weight change..... No Yes
  - Fever..... No Yes
  - Fatigue..... No Yes
  - Headaches..... No Yes
- ***EYES***
  - Eye disease or injury..... No Yes
  - Wear glasses/contact lenses..... No Yes
  - Blurred or double vision..... No Yes
  - Glaucoma..... No Yes
- ***EARS/NOSE /MOUTH/THROAT***
  - Hearing loss or ringing..... No Yes
  - Earaches or drainage..... No Yes
  - Chronic sinus problem or rhinitis..... No Yes
  - Nose bleeds..... No Yes
  - Mouth sores..... No Yes
  - Bleeding gums..... No Yes
  - Bad breath or bad taste..... No Yes
  - Sore throat or voice change..... No Yes
  - Swollen glands in neck..... No Yes
- ***CARDIOVASCULAR***
  - Heart trouble..... No Yes
  - Chest pain or angina pectoris..... No Yes
  - Palpitation..... No Yes
  - Shortness of breath with walking or lying flat. No Yes
  - Swelling of feet, ankles or hands..... No Yes
- ***RESPIRATORY***
  - Chronic or frequent coughs..... No Yes
  - Spitting up blood..... No Yes
  - Shortness of breath..... No Yes
  - Asthma or Wheezing..... No Yes
- ***GASTROINTESTINAL***
  - Loss of appetite..... No Yes
  - Change in bowel movements..... No Yes
  - Nausea or vomiting..... No Yes
  - Frequent diarrhea..... No Yes
  - Painful bowel movements or constipation..... No Yes
  - Rectal bleeding or blood in stool..... No Yes
  - Abdominal pain..... No Yes
  - Peptic ulcer (stomach or duodenal)..... No Yes
- ***GENITOURINARY***
  - Frequent urination..... No Yes
  - Burning or painful urination..... No Yes
  - Blood in urine..... No Yes
  - Change in force of strain when urinating..... No Yes
  - Incontinence or dribbling..... No Yes
  - Kidney stones..... No Yes
  - Sexual difficulty..... No Yes
  - Male - testicle pain..... No Yes
  - Female - pain with periods..... No Yes
  - Female - irregular periods..... No Yes
  - Female - vaginal discharge..... No Yes
  - Female - # of pregnancies..... _____
  - Female - # of miscarriages:..... _____
    _____
- ***MUSCULOSKELETAL***
  - Joint Pain..... No Yes
  - Joint stiffness or swelling..... No Yes
  - Weakness of muscles or joints..... No Yes
  - Muscle Pain or cramps..... No Yes
  - Back Pain..... No Yes
  - Cold extremities..... No Yes
  - Difficulty in walking..... No Yes
- ***INTEGUMENTARY (skin, breast)***
  - Rash or itching..... No Yes
  - Change in skin color..... No Yes
  - Change in hair or nails..... No Yes
  - Varicose Veins..... No Yes
  - Breast pain..... No Yes
  - Breast Lump..... No Yes
  - Breast discharge..... No Yes
- ***NEUROLOGICAL***
  - Frequent or recurring headaches..... No Yes
  - Light headed or dizzy..... No Yes
  - Convulsions or seizures..... No Yes
  - Numbness or tingling sensations..... No Yes
  - Tremors..... No Yes
  - Paralysis..... No Yes
  - Stroke..... No Yes
  - Head injury..... No Yes
- ***PSYCHIATRIC***
  - Memory loss or confusion..... No Yes
  - Nervousness..... No Yes
  - Depression..... No Yes
  - Insomnia..... No Yes
- ***ENDOCRINE***
  - Glandular or hormone problem..... No Yes
  - Thyroid disease..... No Yes
  - Diabetes *(insulin or non insulin - circle one)*..... No Yes
  - Excessive thirst or urination..... No Yes
  - Heat or cold intolerance..... No Yes
  - Skin becoming dryer..... No Yes
  - Change in hat or glove size..... No Yes
- ***HEMATOLOGIC/LYMPHATIC***
  - Slow to heal after cuts..... No Yes
  - Bleeding or bruising tendency..... No Yes
  - Anemia..... No Yes
  - Phlebitis..... No Yes
  - Past transfusion..... No Yes
  - Enlarged glands..... No Yes
- ***ALLERGIC/IMMUNOLOGIC***
  - History of skin reaction or other adverse reaction to:
    - Penicillin or other antibiotics..... No Yes
    - Morphine, Demerol, or other narcotics..... No Yes
    - Novocain or other anesthetics..... No Yes
    - Aspirin or other pain remedies..... No Yes
    - Tetanus antitoxin or other serums..... No Yes
    - Iodine, methiolate or other antiseptic..... No Yes
    - Other drugs/medications: _____
  - Known food allergies: _____
  - Environmental allergies: _____

Reviewed by:_____ Date:_____