PATIENT INFORMATION

|  |  |
| --- | --- |
| Native Language: | |
| Referring Physician’s Full Name: | Telephone #: |
| Physician’s Address: | |
| Are you: □ Right Handed □ Left-handed □ Ambidextrous | |
| Why do you need to see a Neurology specialist? | |
| Past Medical History: | Date of Diagnosis: |
|  |  |
|  |  |
|  |  |
|  |  |
| Hospitalizations / Operations: | Date(s): |
|  |  |
|  |  |
|  |  |
|  |  |
| Injuries – Include any episodes of loss of consciousness: | Date(s): |
|  |  |
|  |  |
| Blood Transfusions: | Date(s): |
|  |  |
|  |  |
| Drug Allergies | Reactions: |
|  |  |
|  |  |
|  |  |
|  |  |

**Medications**

|  |  |  |
| --- | --- | --- |
| Name | Dosage | How Often? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

(Write on back or attach additional sheet if necessary)

**Dietary Supplements / Vitamins:**

|  |  |
| --- | --- |
| Name | Dose and Frequency (how often?) |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

**Social History**

|  |  |
| --- | --- |
| Any use of tobacco (type and for how long)? |  |
| Any use of caffeinated beverages? |  |
| Any use of alcohol (type and for how long)? |  |
| Any use of recreational drugs (type and for how long)? |  |
| Any exposure to toxins/poisonous substances at work or with hobbies? | |
|  |  |
| What type of work do you do? |  |

Education: □ Grade School □High School □College □Post-Graduate □Voc. Training

Marital Status: □Single □Married □Divorced □ Separated □Widowed

Birthplace: ­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History**

Mother: □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Father: □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Brothers/Sisters: List from oldest to youngest.

1. Brother or Sister? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Brother or Sister? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Brother or Sister? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Brother or Sister? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Children: List from oldest to youngest.

1. Daughter or Son? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Daughter or Son? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Daughter or Son? □ Living or □ Deceased? Age: \_\_\_\_\_\_

Health Problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any of your family or relative members had any of the following conditions? If yes, whom?

|  |  |  |  |
| --- | --- | --- | --- |
| Heart Disease |  | Stroke |  |
| High Blood Pressure |  | Fainting |  |
| High cholesterol |  | Diabetes |  |
| Loss of Memory |  | Cancer |  |
| Epilepsy/seizures |  | Multiple sclerosis |  |
| Depression |  | Polio |  |
| Mental disease |  | Limping |  |
| Muscle weakness |  | Thyroid disease |  |
| Other: |  |  |  |

THANK YOU FOR COMPLETING THIS QUESTIONNAIRE.

BE SURE TO BRING IT TO YOUR DOCTOR’S APPOINTMENT.

**REVIEW OF SYSTEMS**

*Please place a checkmark if you currently have any of the following symptoms.*

1. Constitutional □ fever □weight loss □fatigue

2. Eye problems □blurred vision □double vision □loss of vision

□eye pain □eye redness □eye dryness

3. Ear/Nose/Throat □trouble hearing □ringing in ear(s) □dizziness (vertigo)

□loss of balance □ear pain □ear discharge

□hoarseness □trouble swallowing □slurred speech

4. Cardiovascular □chest pain □irregular heart □fast heart beat

□limb swelling □limb pain on walking □fainting

5. Respiratory □trouble breathing □chronic cough □coughing blood

6. Gastrointestinal □indigestion □heart burn □abdominal pain

□nausea □vomiting □regurgitation

□diarrhea □constipation □bloody stools

7. Genitourinary □incontinence □pain on urination □blood in urine

8. Musculoskeletal □muscle pain □muscle cramps □muscle twitches

□loss of muscle bulk □neck pain □back pain

□joint pain □joint stiffness □joint swelling

9. Skin & breast □numbness □tingling □discoloration

10. Neurologic □headache □face pain □face numbness

□weakness □tremors □clumsiness

□blackouts □trouble □trouble concentrating

11. Psychiatric □hallucinations □feeling depressed □trouble sleeping

□suicidal thoughts □inappropriate crying □inappropriate

laughing

12. Hematological/Lymphatic □abnormal bleeding □nose bleeds □lumps or swellings

13. Allergic/immunologic □skin rash □joint pain □dry eyes

14. Endocrine □excessive thirst □heat or cold □excessive urination

Intolerance

Patient or Representative Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If signed by someone other than the patient, please specify relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Interpreter Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_