Patient Name: _____ Today's Date: _____

Birthdate: _____

Neurological Symptoms

On a scale of 1-10 (10 being the worst), what is your current level of pain? _____

Reason for visit: (Please provide a brief history of your symptoms)

_____
_____
_____
_____

This visit is an:

□ Initial Consult □ Second Opinion (treatment has already been recommended by another provider)

Have you seen any other providers related to this condition (Neurologist, Oncologist, Ophthalmologist, ENT, etc.)? □ Yes □ No

If yes, provider/clinic name _____

Were you referred to us by a specific provider? □ Yes □ No

If yes, please list provider name and clinic: _____

Check any symptoms you have been experiencing: □ None

□ Dizziness □ Lightheaded □ Vision Changes □ Hearing Changes □ Speech Changes

□ Headache □ Numbness □ Tingling □ Loss of Balance □ Facial Paralysis

□ Seizures □ Confusion □ Disorientation

Are your symptoms: □ Recurring □ Improving □ Worsening

What is the severity of your symptoms: □ Mild □ Moderate □ Severe □ Incapacitating

□ Other _____

How often do your symptoms occur: □ Constantly □ Daily □ Weekly □ Randomly

□ Other _____

Medications:

List any medications that you are currently taking including all pain medications.

□ None

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Primary Pharmacy

Pharmacy Name/Address/City: _____

Allergies:

Select any allergies from the list:

□ No known allergies

□ Accupril (Quinapril)
□ Acetaminophen
□ Acyclovir
□ Advil (Ibuprofen)
□ Altace (Ramipril)
□ Ampicillin
□ Amaryl (Glimepiride)
□ Augmentin (Amoxicillin)
□ Aspirin
□ Bactrim
□ Ceclor (Cefaclor)
□ Celebrex
□ Cephalosporins
□ Cipro (Ciprofloxacin)
□ Compazine (Promazine)
□ Contrast Media (Ioversol)
□ Codeine
□ Coumadin
□ Darvon
□ Demerol
□ Depakote
□ Doxycycline
□ Egg
□ Erythromycin
□ Famotidine
□ Flagyl
□ Floxin
□ Gabapentin
□ Glucotrol(Glipizide)
□ Heparin
□ Hydrocodone
□ Ibuprofen
□ Inderal (Propranolol)
□ Indocin (Indomethacin)
□ Insulin
□ Iodine or Shellfish
□ IVP Dye
□ Keflex (Cephalexin)
□ Klonopin
□ Lasix (Furosemide)
□ Latex
□ Levofloxacin
□ Levaquin
□ Lidocaine
□ Lipitor
□ Lisinopril
□ Lodine
□ Lopressor (Metoprolol)
□ Morphine
□ Motrin (Ibuprofen)
□ Naprosyn (Naproxen)
□ Niacin
□ Oxycodone
□ Peanut
□ Penicillin
□ Percocet (Oxycodone)
□ Plavix
□ Prednisone
□ Prevacid
□ Prilosec
□ Ranitidine
□ Sulfa
□ Tagamet (Cimetidine)
□ Tetanus Toxoid
□ Tetracycline
□ Tramadol
□ Valium (Diazepam)
□ Vancomycin
□ Zithromax
□ Zocor (Simvastatin)
□ Zyloprim (Allopurinol)

_____
_____
_____
_____

Medical History: Select all current and past medical conditions and include the year of diagnosis

□ None

□ Aneurysm _____
□ Brain Tumor _____
□ AVM _____
□ Abnormal Heart Rhythm _____
□ Anemia _____
□ Asthma _____
□ Cancer _____
□ Liver Disease _____
□ Hypertension _____
□ Inflammatory Bowel _____
□ Depression _____
□ Diabetes _____
□ Endometriosis _____
□ Ovarian Cyst _____

□ Heart Attack _____
□ Osteoarthritis _____
□ Tuberculosis _____
□ Bronchitis _____
□ Emphysema _____
□ Hepatitis _____
□ Irritable Bowel _____
□ Stomach Ulcer _____
□ Kidney Failure _____
□ Anesthetic Complications _____
□ Anorexia _____
□ Bulimia _____
□ Kidney Stones _____
□ Rheumatoid Arthritis _____

□ Bleeding Disorder _____
□ Blood Clots _____
□ HIV _____
□ Alcoholism _____
□ Scoliosis _____
□ Seizure(s) _____
□ Sleep Apnea _____
□ Stroke _____
□ Thyroid Disease _____
□ Anxiety _____
□ Schizophrenia _____
□ Low Potassium _____
□ Osteoporosis _____
□ COPD _____

Surgical History: **Year** **Year**

□ No Previous Surgery

□ Abdominal Surgery _____
□ Angioplasty _____
□ Back Surgery _____

If you have had back surgery, what part of your back?

- □ Lumbar (Lower Back)
- □ Thoracic (Middle Back)
- □ Unknown

If you have had back surgery, was this a Fusion Surgery?

□ Yes □ No □ Unknown

□ Aneurysm Clip/Coil _____
□ Brain Tumor Removal _____

□ AVM Repair _____
□ CABG _____
□ Cardiac Pacemaker _____
□ Gastric Bypass _____
□ Hip Replacement _____
□ Knee Replacement _____
□ Mastectomy _____
□ Neck Surgery _____
□ Rotator Cuff Repair _____
□ Thyroidectomy _____
□ _____ _____
□ _____ _____

List any prior diagnostic tests and treatments

Test/Treatment	Date(s)	Body Area Tested/Treated	Facility
CT			
MRI			
MRA / CTA			
X-ray			
CT Perfusion			
Radiation			
Cerebral Angiogram			

Family Medical History (circle family member if known)

□ Alcoholism	Brother	Father	Mother	Sister
□ Alzheimer's disease	Brother	Father	Mother	Sister
□ Asthma	Brother	Father	Mother	Sister
□ Bleeding/Blood Disorder	Brother	Father	Mother	Sister
□ Cancer	Brother	Father	Mother	Sister
□ Cardiovascular Disease	Brother	Father	Mother	Sister
□ Colitis	Brother	Father	Mother	Sister
□ Congenital Heart Disease	Brother	Father	Mother	Sister
□ COPD	Brother	Father	Mother	Sister
□ Coronary Artery Disease	Brother	Father	Mother	Sister
□ Depression	Brother	Father	Mother	Sister
□ Diabetes	Brother	Father	Mother	Sister
□ Elevated Lipids	Brother	Father	Mother	Sister
□ Genetic Disease	Brother	Father	Mother	Sister
□ High Blood Pressure (Hypertension)	Brother	Father	Mother	Sister
□ Liver Disease	Brother	Father	Mother	Sister
□ Mental Illness	Brother	Father	Mother	Sister
□ Obesity	Brother	Father	Mother	Sister
□ Osteoporosis	Brother	Father	Mother	Sister
□ Parkinson's disease	Brother	Father	Mother	Sister
□ Kidney/Renal Disease	Brother	Father	Mother	Sister
□ History of Seizure(s)	Brother	Father	Mother	Sister
□ Stroke	Brother	Father	Mother	Sister
□ Thyroid Disorder	Brother	Father	Mother	Sister

Social History:

Marital status: □ Married □ Single □ Divorced □ Widowed

Children: □ Yes □ No Number of Sons _____ Number of Daughters _____

Hand Dominance: □ Right-Handed □ Left-Handed □ Ambidextrous

Occupation: _____

Employment Status: _____

Restrictions: _____

Have you ever used tobacco? □ No/Never □ Yes □ Former – Age when you quit _____

Type of tobacco used: _____

If cigarettes, how many packs per day? _____

Have you ever had a problem with drug dependency? □ Yes □ No

Do you drink alcohol? □ Yes – how much? _____ □ No

Review of Systems

Select **POSITIVE** if you are experiencing any of these symptoms, select **NEGATIVE** if you are not experiencing any of these symptoms.

Description	Positive (Yes)	Negative (No)	Office Use Only
Fever	☐	☐	Constitutional
Chills	☐	☐	Constitutional
Blurred Vision	☐	☐	Eyes
Double Vision	☐	☐	Eyes
Difficulty swallowing (Dysphagia)	☐	☐	ENT
Chest Pain	☐	☐	Cardiovascular
Shortness of Breath (Dyspnea)	☐	☐	Respiratory
Heartburn	☐	☐	Gastrointestinal
Nausea	☐	☐	Gastrointestinal
Vomiting	☐	☐	Gastrointestinal
Urinary Incontinence (leaky urine)	☐	☐	Genitourinary
Joint Pain	☐	☐	Musculoskeletal
Muscle Spasm	☐	☐	Musculoskeletal
Rashes	☐	☐	Integumentary (skin)
Numbness	☐	☐	Neurologic
Tingling	☐	☐	Neurologic
Bruising	☐	☐	Hematologic
Hair Loss	☐	☐	Endocrine
Seasonal Allergy	☐	☐	Allergic
Depression	☐	☐	Psychiatric

Global Health Screening

Please respond to each item by marking one box per row.

	Excellent	Very Good	Good	Fair	Poor
1. In general, would you say your health is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
2. In general, would you say your quality of life is:	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
3. In general, how would you rate your physical health?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
4. In general, how would you rate your mental health, including your mood and your ability to think?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
5. In general, how would you rate your satisfaction with your social activities and relationships?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1
6. In general, please rate how well you carry out your usual social activities and roles. (This includes activities at home, at work and in your community, and responsibilities as a parent, child, spouse, employee, friend, etc.)	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

	Completely	Mostly	Moderately	A little	Not at all
7. To what extent are you able to carry out your everyday physical activities such as walking, climbing stairs, carrying groceries, or moving a chair?	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

In the past 7 days . . .

	Never	Rarely	Sometimes	Often	Always
8. How often have you been bothered by emotional problems such as feeling anxious, depressed or irritable?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

	None	Mild	Moderate	Severe	Very Severe
9. How would you rate your fatigue on average?	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

10. How would you rate your pain on average?

No pain										Worst Imaginable Pain
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10