NEUROLOGY NEW PATIENT INFORMATION SHEET

Date: ____________

Name: ____

Age: ______ **Gender**: ______ **Which is your dominant hand** (e.g., use to write, eat)? ____________________

Referring physician (name): ____
Address: ____
Phone: ____

Please list your other current physicians (name, address, and phone number): ______________________________
____
____
____

What Is The Problem For Which You Have Come To See Us? ____
____

When did this problem start? ____

Do you have or have you had any of the following problems?

Condition	Yes	No
Memory Loss		
Alzheimer's disease		
Loss of consciousness		
Dizziness/vertigo		
Seizures/epilepsy		
Stroke/TIA		
Visual loss		
Double vision		
Loss of Hearing		
Ringing in the Ears		
Loss of Smell		
Speech difficulties		
Swallowing difficulties		
Headache		
Face Pain		
Neck Pain		
Back Pain		
Leg Pain/sciatica		
Muscle Pain		
Weakness		
Clumsiness		
Tremor/shaking		
Involuntary movements		
Difficulty walking		
Parkinson's disease		

Condition	Yes	No
Unexplained Fever		
Unexplained weight loss		
Fatigue		
Heart Attack		
Angina		
Heart Failure		
Heart Arrhythmia		
Heart Valve Problem		
Heart Murmur		
High blood Pressure		
High Cholesterol		
Poor circulation		
Shortness of breath		
Unexplained cough		
Asthma		
COPD/emphysema		
Bronchitis		
Pulmonary embolus		
Blood clot in legs		
Unexplained nausea/vomiting		
Unexplained diarrhea		
Stomach/intestinal bleeding		
Ulcer		
Jaundice		
Hepatitis		

Condition	Yes	No
Cirrhosis		
Bleeding in the urine		
Difficulties urinating		
Incontinence		
Sexual difficulties		
Joint Pains		
Arthritis		
Rash		
Diabetes mellitus		
Thyroid problem		
Depression		
Anxiety		
Hallucinations		
Allergies		
Tuberculosis		
HIV/AIDS		
Anemia		
Easy bleeding/bruising		
Cancer		
Sleep difficulties		
Other (list)		

List all hospitalizations and operations:
____
____
____
____

PLEASE COMPLETE THE OTHER SIDE

Reviewed____________

Date: ____________________________ **Name:** ____

Current Medications

Medication	**Dose (mg)**	**Doses/Day**	**Medication**	**Dose (mg)**	**Dose/Day**

Medication Allergies: ____

____

Family History *alive/dead (age)* *illnesses*

Mother ____

Father ____

Brother/Sister ____

Brother/Sister ____

Brother/Sister ____

Brother/Sister ____

Child ____

Child ____

Child ____

List any neurological diseases in your family: ____

____

Are you currently working? ☐ yes ☐ no. Occupation (current /previous): ______________________________

Marital Status: ☐ single ☐ married ☐ separated/divorced ☐ widowed. Number of children: ______________

Education: ☐ less than high school graduate ☐ high school graduate ☐ college graduate

Do you ***currently*** **smoke**? ☐ yes ☐ no. How much? ____

If no, did you ***ever*** smoke? ☐ yes ☐ no. When did you stop? ___________________________________

Do you ***currently*** **drink *any* alcohol**? ☐ yes ☐ no. How much? ____

If no, did you ***ever*** drink alcohol? ☐ yes ☐ no. How much and when? ______________________________

Do you ***currently*** use ***any*** **recreational drugs**? ☐ yes ☐ no. Which one(s)? _____________________________

If no, did you ***ever*** use recreational drugs? ☐ yes ☐ no. Which one(s)? _____________________________

Do you **exercise**? ☐ yes ☐ no. What type and how much? ____

With whom do you live? ____

If a woman, are you pregnant? ☐ yes ☐ no. If not, **when was your last menstrual period**? ______________

Or, if menopausal, at what age? ______________