

Patient Information

Today's Date _____

Name _____
Last First Middle Initial

Date of birth _____ Age _____

Address _____
Street Apt
City State Zip

Phone _____ Home _____
Work _____

Marital Status S M W D

Spouses Name _____

Occupation _____

Name of doctor referring you here _____

Family doctor if different from above _____

Reason for visit: What symptoms are you having, and when did they start? _____

Have you missed any days of work due to this problem? No Yes Dates _____

Are you currently on medical leave or disability? No Yes Last day worked _____

Is this problem due to injury? No Yes Describe what happened: _____

Date of injury _____ Did it happen at work? No Yes Auto Accident? No Yes

Have you been evaluated for this problem in the past? No Yes

If so, when and where _____

List current medications, including nonprescription drugs _____

List any medical conditions and/or hospitalizations _____

PHARMACY NAME: _____

PHONE _____ FAX: _____

Medication Allergies _____

Have you ever had the following tests/consults?
If yes - where and when

Other Allergies _____

CT _____

MRI _____

Angiogram _____

EMG _____

EEG _____

Myelogram _____

Holter EKG (24hr) _____

Spinal Tap _____

Previous Neurological Consultation _____

Do you smoke? No Yes How Much? _____

Have you ever smoked? No Yes For How Long? _____

Amount of alcohol consumed weekly? _____

Continued.....

Do you snore loudly? (louder than talking or loud enough to be heard through closed doors) _____

Do you often feel tired, fatigued, or sleepy during the daytime? _____

Has anyone observed you stop breathing during your sleep? _____

Do you have or are you being treated for high blood pressure? _____

Check any of the following that you have had:

- | | |
|--|------------------------------------|
| _____ 1. Neck Pain | _____ 19. Sleeping Problems |
| _____ 2. Back Pain | _____ 20. Snoring |
| _____ 3. Arm / Leg Pain | _____ 21. Seizures |
| _____ 4. Joint Pain | _____ 22. Blackout Spells |
| _____ 5. Numbness / Tingling | _____ 23. Memory Loss |
| _____ 6. Weakness / Paralysis | _____ 24. Anxiety |
| _____ 7. Difficulty Walking | _____ 25. Depression |
| _____ 8. Falling | _____ 26. Chest Pain |
| _____ 9. Balance / Coordination Problems | _____ 27. Palpitations |
| _____ 10. Movement Disorder or Tremor | _____ 28. Cardiac / Heart Problems |
| _____ 11. Bladder Symptoms | _____ 29. Bloating |
| _____ 12. Impotence | _____ 30. Stomach Pain / Distress |
| _____ 13. Dizziness | _____ 31. Bowel Problems |
| _____ 14. Speech Disturbance | _____ 32. Respiratory Problems |
| _____ 15. Difficulty Swallowing | _____ 33. Skin Changes / Rash |
| _____ 16. Ringing In Ears | _____ 34. Weight Gain or Loss |
| _____ 17. Hearing Loss | _____ 35. Appetite Problems |
| _____ 18. Visual Symptoms | |

Family History

Do you or any blood relative have a history of:

Please Check	<input checked="" type="checkbox"/>	Self	<input checked="" type="checkbox"/>	Relative
Stroke				
Heart Attack				
High Cholesterol				
High Blood Pressure				
Diabetes				
Epilepsy or Seizures				
Migraine or Severe Headache				
Bleeding Tendency				
Tremor or Movement Disorder				
Parkinsons Disease				
Multiple Sclerosis				
Mental Illness				
Memory Loss / Alzheimer's				
Arthritis				
Visual Loss				
Nervous Breakdown				
Suicide or Attempt				
Depression				
Osteoporosis (Brittle Bones)				
Cancer / Leukemia				
Sleep Disorder				

If living: present age & any chronic medical condition

or

Age at death and cause

Father	_____	_____
Mother	_____	_____
Sister(s)	_____	_____
Brother(s)	_____	_____
Children	_____	_____
Husband/Wife	_____	_____