NEUROLOGICAL CONSULTANTS, P.C.

Name _____ Today's Date_____

Referred by _____ Age _____ Dr. _____

Please answer each of the following questions briefly; your doctor will review them with you.

Which symptom or problem would you like addressed today?

_____

Where do you feel this problem in your body?

_____

How long have you ever had these symptoms?

_____

When these symptoms occur, how long do they last?

_____

How often do these symptoms occur, on average?

_____

What is the severity of these symptoms? (please circle)
Mild Moderate Severe Intolerable

What does this problem feel like? How would you describe it?

_____

What makes this problem worse? What makes it better?

_____

Are there other symptoms that occur along with this problem?

_____

What over the counter medications have you tried for this problem?

_____

What prescription medications have you tried for this problem?

_____

Which medications, if any, have been helpful?

_____

Have you had any medical tests to evaluate these symptoms? When?

_____

Past Medical History

Stroke/"mini" stroke?_____

Headaches/migraines?_____

Seizure/Epilepsy?_____

Heart Disease?_____

High blood pressure? _____

Diabetes? _____

Other: _____

_____

_____

_____

What is your current height? _____ and current weight?_____

Past Surgical History

_____ Year:_____

_____ Year:_____

_____ Year:_____

_____ Year:_____

_____ Year:_____

Social History

Education Level: GED High School Technical College Post-Graduate

Current Job Title _____

Alcohol Use: (please circle) Never Rarely Weekly Daily Amount: _____

Tobacco Use: (please circle) Never Quit (what year? _____) Currently Pack(s) per day: _____

Illicit Drug Use: (please circle) Never Occasionally Daily Substance:_____

Have you ever required a: cane walker brace wheelchair

Do you need help with bathing or dressing? Yes No Are you currently on disability? Yes No

Marital Status: (please circle) Single Married Partner Divorced Separated Widowed

Do you exercise regularly? What is your usual routine? _____

Who lives with you at home? _____

How many children do you have? ___ Sons ___ Daughters Any miscarriages? ___

How many siblings do you have? ___ Brothers ___ Sisters ____ Are you adopted? ____

Are you **allergic** to any medications? What side effects occur? Or circle NO KNOWN ALLERGIES

_____

_____

All current medications:

PRESCRIPTION MEDICATIONS	DOSE (MG)	TIMES PER DAY

OVER THE COUNTER MEDICATIONS	DOSE	TIMES PER DAY
Aspirin?		

Family History

DISEASES IN OTHER FAMILY MEMBERS	YES/NO	RELATIONSHIP TO YOU
Migraine headaches		
Seizure or epilepsy		
Parkinson's disease		
Alzheimer's disease or dementia		
Stroke or bleeding in the brain or aneurysm		
Huntington's disease		
Bleeding or blood clotting disorders		
Heart disease		
Depression		
Other:		

For office use only: Physician time face to face IN: _____ OUT: _____ Circle if >50% counseling or coordinating care

Do you now have, or have you recently had, any of these symptoms?
Circle Yes or No

Constitutional Symptoms Fever/Chills Y N Weight gain/loss ____lbs Y N Headache/Migraine Y N Other_____	Integumentary Skin rash Y N Boils Y N Persistent itch Y N Other_____
Eyes Blurred vision Y N Double vision Y N Sudden loss of vision Y N Other_____	Musculoskeletal Joint pain Y N Neck pain Y N Back pain Y N Other_____
Allergic/Immunologic Hay Fever Y N Drug allergies Y N Other_____	Ear/Nose/Throat/Mouth Ear infection Y N Sore throat Y N Sinus problems Y N Other_____
Neurological Tremors Y N Muscle twitching/jerking Y N Numbness/tingling/burning Y N Poor balance/falls Y N Other_____	Genitourinary Urinary retention Y N Urinary urgency/frequency Y N Sexual dysfunction Y N Incontinence Y N Other_____
Endocrine Excessive thirst Y N Too hot/too cold Y N Tired/sluggish Y N Other_____	Respiratory Wheezing Y N Frequent cough Y N Shortness of breath Y N Other_____
Gastrointestinal Abdominal Pain Y N Nausea/vomiting Y N Indigestion/heartburn Y N Other_____	Hematological/Lymphatic Swollen glands Y N Blood clotting problem Y N Other_____
Cardiovascular Chest pain Y N Varicose veins Y N High blood pressure Y N Other_____	Psychological Are you generally pleased with life? Y N Do you feel depressed? Y N Have you considered suicide? Y N Other_____

To help obtain meaningful use for our electronic medical records please answer the following questions.

If you do not feel comfortable answering any of the questions please select “decline” for your answer.

1) What is your race?
   a) American Indian or Alaska Native
   b) Asian
   c) Black or African American
   d) Native Hawaiian or Pacific islander
   e) White
   f) Other race
   g) Decline

2) What is your ethnic group?
   a) Hispanic or Latino
   b) NOT Hispanic or Latino
   c) Decline

3) What is your spoken language?
   a) English
   b) Spanish
   c) Russian
   d) Chinese
   e) German
   f) Vietnamese
   g) French
   h) Arabic
   i) Other
   j) Decline