



Patient Information/Questionnaire

Neurology

PATIENT INFORMATION

Street Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Home Phone: _____ Cell Phone: _____

Marital Status: Single Married Divorced Widowed Separated Other _____

Work Status: Employed Retired Disabled Self-Employed Unemployed Other: _____

Employer Name: _____ Work Phone: _____

MEDICAL DECISION MAKING

Health Care Decision Maker (in the event the patient is incapacitated):

Name/Relationship to patient: _____ Legally appointed: Yes N

Phone number: _____ (if yes, please provide documentation)

PHARMACY INFORMATION

Pharmacy: _____ Pharmacy Phone #: _____

PHYSICIAN INFORMATION

Referring Physician's Name: _____ Practice Name: _____

Primary Care Physicians Name: _____ Practice Name: _____

PAST MEDICAL HISTORY

List all major illnesses and conditions you have ever been diagnosed with (ex: High Blood Pressure, Heart Disease, Diabetes, etc.): _____

Past Surgical History:

<u>Surgery</u>	<u>Year</u>	<u>Surgery</u>	<u>Year</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

DRUG ALLERGIES

Do you have any drug allergies?

- No** know drug allergies
- Yes** (please list drug and reaction below)

- 1. _____
- 2. _____
- 3. _____

Allergic to **shellfish** or **X-ray dye**? Yes No (List reaction below)

Allergic to **Latex**? Yes No (List reaction below)

Shellfish or Xray dye reaction: _____

Latex reaction: _____

MEDICATIONS

Please list or request that our front desk copy your medication list upon check-in. (include non-prescription drugs with dosages):

Medication	Dosage (mg)	Frequency	Medication	Dosage (mg)	Frequency

REVIEW OF SYSTEMS

Please check the box if you have experienced any of these problems recently. (Please check all that apply to you.)

Cardiovascular: Palpitations Chest pain Leg Swelling

Hematology: Excessive bruising Swollen lymph nodes

Musculoskeletal: Joint Pain/Swelling Muscle Pain/Weakness Trauma/Fractures

Respiratory: Shortness of Breath Chronic Cough

Neurologic: Numbness Paralysis Seizures Migranes/Headaches Memory Loss

Gatrointestinal: Nausea/Vomiting Diarrhea

Constitutional : Unintentional weight loss Fever Fatigue

Genitourinary: Urinary Frequency Painful Urination Urinary Incontinence Unrinary Retention

Psychiatric: Anxiety Depression Thoughts of hurting yourself or others

Endocrine: Increased thirst Excessive sweating

Infectious: Hepatitis Frequent Infections

ENT: Sore Throat Hearing Loss

Skin: Rash Itching

Eyes: Blurry Vision Eye Pain