Name: _____Age:_____ Date Of Birth_____

1. Please describe the problem that you would like addressed, what it consists of, how and when it started, what worsens and relieves it?

_____
_____
_____
_____

2a. Who is your primary physician?
_____
_____
Phone Number_____

2b. What physicians have you seen for this problem?
_____
_____

3. List all illness and or hospitalizations and surgeries you have had during your life:
_____
_____
_____
_____

4.List the name and dose for each prescription and over the counter medication you are currently taking.

Medication:	**Dose:**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

5.Any Allergies and reactions when you take them?
_____
_____
_____

6. What has been done for your problem? Medications, physical therapy, surgery, other?

Treatment	**Date:**	**Results:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Have you had any of the following test?

Test	**Date**	**Where**
MRI		
CT		
Carotid Doppler		
EMG		
EEG		
SPECT/PET		

Other: (myelogram, angiogram, biopsy, spinal tap)

_____

_____

8. Do you use tobacco? ☐ Yes ☐ No Packs per day___ Number of years ___ Quit Date___

Do you use alcohol? ☐ **Yes** ☐ **No** ☐ Beer ☐ Wine ☐ Liquor ☐ **Daily** ☐ **Weekly** ☐ **Socially**

Are you disabled? ☐ Yes ☐ No If yes, since when?_____

Who lives with you at home?_____

Describe your work (if applicable)

_____

_____

9. Please **circle** all that apply to you:

Neurologic:
Headache, change in taste smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremors, confusion, memory loss, head trauma, sleeping problems, stroke or TIA (mini stroke).

Constitutional: Fevers, chills, fatigue, weight loss, weight gain, HIV/AIDS.

Eyes:
Blurred vision, double vision, decreased vision, cataract, glaucoma.

Ears, Nose, Throat, Mouth:
Hearing loss, ringing in ears, earache, hoarseness, vertigo (spinning).

Cardiovascular:
Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory:
Cough, emphysema, asthma.

Gastro- Intestinal:
Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis.

Genito-Urinary:
Urinary incontinence, urinary frequency, urinary urges, sexual dysfunction, kidney problems.

Skin:
Rash or other skin abnormalities.

Musculoskeletal:
Joint pain, swelling, stiffness, neck pain, lower back pain, muscle aches.

Psychiatric:
Depression, anxiety other psychiatric problems.

Endocrine:
Diabetes, thyroid problems, hormonal problems.

Hematologic:
Anemia, easily bruises, bleeding disorder.

Have you ever had cancer? ☐ Yes, Please Describe_____ ☐ No

10.Tell us about your family's health:

	Living/deceased	Health Issues
Mother		
Father		
Brother		
Brother		
Brother		
Sister		
Sister		
Sister		

Any family history of: ☐ Dementia ☐ Stroke ☐ MS ☐ Seizure ☐ Parkinson's

If so who?_____

11. What do you hope to achieve with your doctor?

_____

_____

_____

12. Emergency Contact:

Name: _____Relationship: _____

Phone Number:_____

_____ _____

Patient Signature Date