

PERSONAL INFORMATION

Today's Date: _____
NAME (LAST) _____, (FIRST): _____ (MIDDLE) _____
 BIRTHDATE: _____ AGE: _____ SEX: _____
 HEIGHT: _____ WEIGHT: _____ SOC.SEC # : _____
 ADDRESS: _____
 _____ CITY: _____ ST.: _____ ZIP: _____

HOME PHONE (area code): _____ **HOME FAX:** _____

***** **Completion of physician names below is required in order for them to receive your consult note.** *****

REFERRING PHYSICIAN: (LAST) _____, (FIRST): _____

PRIMARY PHYSICIAN: (LAST) _____, (FIRST): _____

OTHER CONSULTANTS (PHYSICIANS): _____

EMPLOYER: _____ **OCCUPATION:** _____

WORK ADDRESS: _____

WORK NUMBER (area code): _____

EMERGENCY PHONE NUMBER (area code): _____

ARE YOU THE PRIMARY INSURED: _____ **IF NOT COMPLETE SECTION BELOW:**

INSURED NAME: _____ **RELATIONSHIP:** _____

EMPLOYED BY: _____ **WORK ADDRESS:** _____

BIRTHDATE OF THE INSURED: _____

SOC.SEC# OF INSURED: _____

PLEASE PRESENT (1) INSURANCE CARD AND (2) DRIVER LICENSE FOR COPY
 PLEASE SIGN BELOW GIVING US PERMISSION TO FILE ON YOUR INSURANCE
 AND RELEASE INFORMATION TO YOUR INSURANCE COMPANY IF NECESSARY
 TO PROCESS YOUR CLAIM. I REALIZE THAT I AM RESPONSIBLE FOR WHAT MY
 INSURANCE DOES NOT PAY.

SIGN: _____ **DATE:** _____

CLINICAL INFORMATION

PLEASE COMPLETE IN DETAIL AND LEAVE NO BLANKS.
MY STAFF WILL BE GLAD TO HELP YOU.

NAME: (LAST): _____ (FIRST): _____
AGE: _____ SEX: _____ RIGHT-HANDED LEFT-HANDED

WHAT DIFFICULTIES BRING YOU TO THE NEUROLOGIST: _____

WHEN DID THIS START? _____

REVIEW OF SYSTEM:

DO YOU HAVE ANY OF THE SYMPTOMS LISTED BELOW THAT ARE SIGNIFICANT AND FREQUENT? YES NONE

IF YES, PLEASE MARK THE APPROPRIATE CHOICES.

- | | | |
|------------------------------|---------------------------------|------------------------------|
| Progressive Body Weight Loss | Bowel/ bladder incontinence | Severe incoordination |
| Fever | Chronic neck/ arm pain | Progressive loss of balance |
| Severe visual loss/blindness | Chronic back/ leg pain | Constant night leg jerks |
| Double vision (not blurry) | Skin rashes; Skin discoloration | Marked depression |
| Severe trouble hearing | Severe dizziness | Marked nervousness |
| Slurred speech | Headache | Marked memory loss |
| Irregular heart rate | Numbness at extremity | Severe trouble sleeping |
| Heavy snoring | Weakness at extremity | Cold intolerance |
| Sleep apnea (stop breathing) | Trouble walking | Marked daytime sleepiness |
| Difficulty swallowing | Tremor/ shaking | Severe joint pain/ arthritis |

PREVIOUS TESTS (done for your illnesses): NONE

- MRI: Head _____ Neck _____ Back _____ Other _____
When _____ Where _____ Per Dr.: _____
- CAT SCAN: Head _____ Neck _____ Back _____ Other _____
When _____ Where _____ per Dr.: _____
- X-RAYS: Head _____ Neck _____ Back _____ Other _____
When _____ Where _____ per Dr.: _____
- BLOOD LAB TESTS: _____
When _____ Where _____ Per Dr.: _____

CLINICAL INFORMATION (cont.)

OPERATIONS: NONE

1) _____ 2) _____

3) _____ 4) _____

Others: _____

FAMILY HISTORY (OTHER THAN YOU): NONE

explain who and what kind

Stroke: _____

High Blood Pressure : _____

Diabetes: _____

Heart Coronary Artery Disease: _____

Psychiatric Disorder: _____

Inherited Family Disease: _____

Seizure: _____

Dementia: _____

Cancer/Tumor: Who and what type: _____

Other Neurological Diseases: _____

SOCIAL HISTORY:

OCCUPATION: _____ MARITAL STATUS: _____

TOBACCO: NEVER PRESENT USE _____ /DAILY FOR ____ YRS; QUIT AT _____

ALCOHOL: NEVER OCCASIONAL
 FREQUENT _____ /DAILY FOR _____ YEARS

FEMALE PATIENT: PREGNANT or BREASTFEEDING

MEDICATIONS: (dose and frequency; give a list if needed)

1) _____ 2) _____

3) _____ 4) _____

5) _____ 6) _____

7) _____ 8) _____

9) _____ 10) _____

OTHERS: _____

DRUG ALLERGIES: NONE
