NEW PATIENT INFORMATION SHEET

OMG-Neurology
Robert H. Choi, M.D., Ph.D.

**This information is for your doctor. Please print legibly.*
***All information will be kept in strict confidence.*

DATE: _____

NAME:_____ **AGE:**____ **HANDEDNESS:** right left **MARITAL STATUS:**_____
REFERRING DOCTOR/PERSON_____

MAIN SYMPTOM(S): "sleep difficulty"

What time do you do to bed? _____
What time do you fall asleep? _____
What time do you wake up in the morning?_____
Do you wake up frequently at night (if yes, how often?)?_____
Do you snore at night?_____
Do you wake-up gasping for breath in the middle of the night? _____
Do you feel refreshed when you wake up in the morning?_____
Do you take any naps? _____
Do you drink any caffeinated beverages? (what? How much?) _____
Any recent weight gain? _____

PAST MEDICAL HISTORY (Please check-off and give duration):

___High Blood Pressure How long?_____years
___Diabetes How long?_____years
___High Cholesterol How long?_____years
___Stroke When and what problem(s)?_____
___Seizure What symptom, when, how often?_____
___Headache Which part of head, since when, how often?_____
___Cancer What type, when?_____
___Operations What kind and when?_____
___Other _____

ALLERGIES TO MEDICATIONS:_____

MEDICATIONS (Please specify name, dose and frequency):

FAMILY HISTORY (Please provide age and any illness in grandparents, parents, siblings or children):

WHAT IS YOUR PROFESSION?_____
DO YOU SMOKE? NO___, YES___ If yes, how many pack/day for how many years? _____
DID YOU SMOKE? NO___, YES___ If yes, how many pack/day for how many years?_____
DO YOU DRINK? NO___, YES___ If yes, what and how often?_____
ANY RECREATIONAL DRUG USE? NO___, YES___ If yes, what and how often? _____

REVIEW OF SYSTEMS (If you checked YES to any of the question below, write the # down on the space provided and describe location, onset, duration, frequency, and last episode of your symptom(s)):

#1. Any recent fevers, shaking chills, night sweats? NO___, YES___
#2. Any recent change in your weight? (how many pounds over what period?) NO___, YES___
#3. Any recent headache? (which part of head, when, how long?) NO___, YES___
#4. Any recent change in your vision? (if yes, describe) NO___, YES___
#5. Any recent change in your hearing? (if yes, describe) NO___, YES___
#6. Any recent chest pain, shortness of breath or heart palpitations? NO___, YES___
#7. Any recent cough or coughing up phlegm (if yes, color and frequency)? NO___, YES___
#8. Any recent diarrhea or constipation? NO___, YES___
#9. Any recent urinary urgency, frequency or pain? (onset, how often?) NO___, YES___
#10. Any recent skin changes? NO___, YES___
#11. Do you feel depressed? (if yes, explain) NO___, YES___
#12. Are you experiencing any hallucinations? (if yes, explain) NO___, YES___

_____
_____
_____
_____
_____
_____

********** DO NOT WRITE BELOW THIS LINE. **********

PHYSICAL EXAMINATION

BP_____ Pulse_____ Weight_____ Height_____

General:

Neurologic:

MD Assessment:

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