

NEW PATIENT INFORMATION SHEET

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

OMG-Neurology

Robert H. Choi, M.D., Ph.D.

Kathleen M. Fitzgerald, M.D.

NAME: _____ DOB: _____ DATE: _____
AGE: _____ HANDEDNESS: right left MARITAL STATUS: _____
REFERRING DOCTOR/PERSON _____

MAIN SYMPTOM(S): "Tremors"

When did you first start noticing tremor? (age____, date_____)

Getting worse, better or about the same? _____

Only on one side, both sides or one side more than the other? _____

Any cause for the weakness? _____

Worse when resting or trying to use your hands? _____

Any problem with balance or walking? _____

Any stiffness or pain in muscles? _____

Worsening constipation? _____

Dizziness when standing? For how long? _____

Any difficulty or change in writing? _____

Any change in your voice? _____

Anything make your tremor worse or better? _____

Test done: CT, MRI, XR, blood test (where, when, result): _____

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):

Any family member with tremor or Parkinson's disease? No____, Yes____ (Who?_____)

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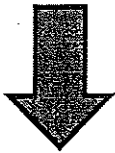
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