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

NEW PATIENT INFORMATION SHEET

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

DOB:_____ **DATE:** _____

NAME:_____ **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 of 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 of 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?_____)

NAME:_____ **DOB:**_____

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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Intentionally left blank