

NEW PATIENT INFORMATION SHEET

OMG-Neurology

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***This information is for your doctor. Please print legibly.*

DATE: _____

NAME: _____ AGE: _____ HANDEDNESS: right left MARITAL STATUS: _____

REFERRING DOCTOR/PERSON _____

MAIN SYMPTOM(S): Bell's Palsy

When did it start & which side is affected? _____

Any pain in the ear, head or face before/after the onset? _____

Treatments taken? _____

Getting better, worse or about the same.? _____

Any change in hearing? _____

Any change in taste? _____

Any changes in vision? _____

Any numbness, weakness or balance problems since the onset? _____

Any testing done for this (blood test, x-ray, etc)? _____

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? _____

**All information will be kept in strict confidence.

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: