**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):** "Headaches"

When did you start having headaches in general? (age_____, date_____)
How often do they happen and how long do they last?_____
Most recent headache? (start_____, duration_____)
Which part of head hurts?_____
Character of pain? (dull, sharp, throbbing, pressure, constant, intermittent)_____
Any symptoms before the onset of headache? (blurry, flashing lights, colored lights, jagged lines, nausea, _____)
Associated symptoms? (nausea, vomiting, dizziness, light sensitivity, numbness, weakness, _____)
Anything bring on headaches? (stress, alcohol, food_____, tired, exercise, light, noise, sex, _____)
Any relief? (some/total relief with sleep, quiet dark room, Tylenol, Exedrin, Aleve, ibuprofen, rest,_____)
Meds tried and response: _____
_____
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?_____
___Any Head/Neck Injury? What and when?_____
___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 brain aneurysm of bleeding? NO___, YES___(Who?_____)
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?_____

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**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