Neurology
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# NEW PATIENT INFORMATION SHEET

**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) for this visit (For each symptom, describe onset, location, duration and frequency):**

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**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___

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

**PHYSICAL EXAMINATION**

BP_____ Pulse_____ Weight_____ Height_____

General:

Neurologic:

**MD Assessment:**