OMG-Neurology

NEW PATIENT INFORMATION SHEET

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

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

	DATE:
NAME:	AGE: HANDEDNESS: right left MARITAL STATUS:_
	REFERRING DOCTOR/PERSON
MAIN SYMPTOM(S): "weakness"	
• • •	
Any cause for the weakness?	
•	
, ·	
Any problems with chewing or swallow	ving?
What type of activities do you have tro	ouble doing because of the weakness?
,,	
PAST MEDICAL HISTORY (Pleas	se check-off and give duration):
High Blood Pressure How long	
Diabetes How long	
High Cholesterol How long	g?years
Stroke When and what probler	
	how often?
Headache Which part of head, sing	nce when, how often?
Operations What kind and when?	
ALLERGIES TO MEDICATIONS:	
	<u> </u>

FAMILY HISTORY (Please provide age and any illness in grandparents, parents, siblings or children):

WHAT IS YOUR PR	ofession?				
DO YOU SMOKE? N	NO, YES If yes, how	many pack/day for how many y	ears?		
DID YOU SMOKE? 1	VO, YES If yes, how	many pack/day for how many ye	ears?		
DO YOU DRINK? N	$IO_{}$, $YES_{}$ If yes, what a	and how often?			
ANY RECREATION	al drug use? no, ye	S If yes, what and how ofter	13		
		ES to any of the question belet, duration, frequency, and			
#I. Any recent fever	s, shaking chills, night sweat	ts? NO. , YES			
#2. Any recent change in your weight? (how many pounds over what period?) NO, YES					
		when, how long?) NO, YES			
#4. Any recent chang	ge in your vision? (if yes, de:	scribe) NO, YES			
#5. Any recent change	ge in your hearing? (if yes, d	lescribe) NO, YES			
		or heart palpitations? NO, `	/ES		
#7. Any recent coug	h or coughing up phlegm (if	yes, color and frequency)? NO	, YES		
	hea or constipation? NO_				
#9. Any recent urina	ry urgency, frequency or pa	nin? (onset, how often?) NO	, YES		
#10. Any recent skin	changes? NO, YES				
#11. Do you feel dep	ressed? (if yes, explain) NC	D, YES			
#12. Are you experie	ncing any hallucinations? (if	yes, explain) NO, YES			
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PHYSICAL EXAM	INATION				
BP	Pulse	Weight	Height		
General:					
Neurologic:					
todi Ologic,					

MD Assessment:

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'	DATE:
NAME:	AGE: HANDEDNESS: right left MARITAL STATUS:
	REFERRING DOCTOR/PERSON
MAIN SYMPTOM(S): "weakness"	
Which part of your body is(are) weak?	
When did it start?	
Any cause for the weakness?	·
Is it persistent or does it come and go?	
Any neck pain?	
Any low back pain?	
Any problems with chewing or swallowing	}
What type of activities do you have trouble	e doing because of the weakness?
Triac type of additions to you have a series	
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	·
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