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:**______

REFFERING DOCTOR/PERSON______________________

MAIN SYMPTOM(S): "Dizziness"

Lightheaded or spinning dizzy ?_ ____

Worse when standing, lying down or turning over in bed?______________________________

How long does it last (seconds, minutes, hours)? ____________________________________

How often does it happen (#/hour, #/day,etc.? ______________________________________

When and how did it start? ____

What caused the dizziness? ____

Any changes in vision when dizzy (blurry, double, black, blind)?_________________________

Any ringing, pain, hearing problem or stuffiness in the ear (which side)? ________________

Any numbness, weakness or balance problems when dizzy?___________________________

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

Any medication tried?____

____

____

____

____

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?___________________

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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