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.*

DATE: ______________________

NAME: ______________________ **AGE:** ____ **HANDEDNESS:** **right** **left** **MARITAL STATUS:** ______

REFERRING DOCTOR/PERSON ______________________

MAIN SYMPTOM(S): "Neck Pain"

When did the neck pain start? ______________________

What brought on the neck pain? ______________________

Does the pain shoot down to your arm(s)? ______________________

Do you have any numbness in your arm/hand? ______________________

Any weakness? ______________________

Any balance problem? ______________________

Any problem controlling your bowel or bladder? ______________________

Any history of injury to your neck? ______________________

Any testing done (blood test, CT, MRI)? ______________________

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___

____

____

____

____

____

____

____

____

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

PHYSICAL EXAMINATION

BP__________ Pulse_____ Weight________ Height________

General:

Neurologic:

MD Assessment: ICD-9 Code Procedure Code

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.

DATE: ____________________

NAME: ______________________________ AGE: ____ HANDEDNESS: right left MARITAL STATUS: ______

REFERRING DOCTOR/PERSON ____________________

MAIN SYMPTOM(S): "Neck Pain"

When did the neck pain start? ______________________________

What brought on the neck pain? ______________________________

Does the pain shoot down to your arm(s)? ______________________________

Do you have any numbness in your arm/hand? ______________________________

Any weakness? ______________________________

Any balance problem? ______________________________

Any problem controlling your bowel or bladder? ______________________________

Any history of injury to your neck? ______________________________

Any testing done (blood test, CT, MRI)? ______________________________

Intentionally left blank