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): "Numbness"

What is numb (right / left, face, arm, leg)?_______________________________

Character or numbness (burning, tingling, shooting, aching)?_______________________________

When did it start?_______________________________

What started the numbness?_______________________________

Are they constant or intermittent (how frequent?)?_______________________________

Any associated pain?_______________________________

Any weakness?_______________________________

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

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?_______________

NAME:______________________________ DOB:________________

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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___

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

PHYSICAL EXAMINATION

BP__________ Pulse_____ Weight________ Height_________

General:

Neurologic:

MD Assessment:

OMG-Neurology

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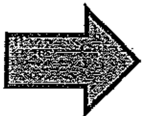

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