

COLLIER NEUROLOGIC SPECIALISTS

Name: _____ Date: _____

Date of birth: _____ How old are you? _____ Dominant hand (circle one): Right Left

Referring physician: _____ Primary Care Physician: _____

Reason for visit: _____ How long? _____

Have you had any of the following treatments: _____ pain medication?
_____ epidural injections?
_____ physical therapy?
_____ surgery?

Do not write in area below:

Empty rectangular box for notes.

Please list current **MEDICATIONS**: _____

Two horizontal lines for listing medications.

Do you have any **ALLERGIES** to medications? No Yes If yes, what medicine and kind of reaction?

Please list any **SURGERIES** or **HOSPITAL ADMISSIONS** (include dates) _____

Three horizontal lines for listing surgeries or hospital admissions.

Social History:

Do you drink alcohol? No Yes If yes, how much and how often? _____
Have you ever smoked? No Yes If yes, how much? _____ How long? _____
Have you quit? No Yes When did you stop? _____
Do you have any children? No Yes If yes, how many? _____
Do you live alone? No Yes If no, with whom? _____
Are you retired? No Yes Occupation (or former occupation): _____

Family History:

Mother Living Deceased Cause of death: _____ Age _____
Father Living Deceased Cause of death: _____ Age _____
Brother/Sister Living Deceased Cause of death: _____ Age _____
Brother/Sister Living Deceased Cause of death: _____ Age _____
Brother/Sister Living Deceased Cause of death: _____ Age _____
Brother/Sister Living Deceased Cause of death: _____ Age _____

Please list any diseases that run in your family: _____

OVER

Please check [√] any **medical conditions** listed below that you have been diagnosed to have:

- | | | |
|--|--|--|
| <input type="checkbox"/> high blood pressure | <input type="checkbox"/> bowel or bladder problems | <input type="checkbox"/> arthritis/gout |
| <input type="checkbox"/> heart disease/angina/heart attack | <input type="checkbox"/> stomach ulcers | <input type="checkbox"/> stroke |
| <input type="checkbox"/> irregular heartbeat | <input type="checkbox"/> prostate problems | <input type="checkbox"/> polio |
| <input type="checkbox"/> high cholesterol | <input type="checkbox"/> kidney stones | <input type="checkbox"/> blood clots |
| <input type="checkbox"/> ear/nose/throat problems | <input type="checkbox"/> diabetes | <input type="checkbox"/> anemia |
| <input type="checkbox"/> COPD/emphysema/asthma | <input type="checkbox"/> thyroid problems | <input type="checkbox"/> cancer (type) _____ |
| <input type="checkbox"/> other (please list) _____ | | |

Please check [√] any **current problems** you may have: (Review of Systems)

- | | | | |
|--|---|---|--|
| <u>Constitutional</u> | <u>Cardiovascular</u> | <u>Genitourinary</u> | <u>Neurologic</u> |
| <input type="checkbox"/> Weight loss | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Slurred speech |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Palpitations | <input type="checkbox"/> Urinary frequency | <input type="checkbox"/> Vertigo/dizziness |
| <input type="checkbox"/> Poor sleep | | <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Memory loss |
| | <u>Respiratory</u> | | <input type="checkbox"/> Focal weakness |
| <u>Eyes</u> | <input type="checkbox"/> Shortness of breath | <u>Musculoskeletal</u> | <input type="checkbox"/> Focal numbness |
| <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Cough | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Problems walking |
| <input type="checkbox"/> Loss of vision | <input type="checkbox"/> Sputum | <input type="checkbox"/> Hand joint pain | |
| <input type="checkbox"/> Double vision | | <input type="checkbox"/> Wrist pain | <u>Skin</u> |
| <input type="checkbox"/> Eye pain | <u>Gastrointestinal</u> | <input type="checkbox"/> Elbow pain | <input type="checkbox"/> Moles changing |
| | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Rash |
| <u>Ears/Nose/Throat</u> | <input type="checkbox"/> Constipation | <input type="checkbox"/> Hip pain | <input type="checkbox"/> Poor healing |
| <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Knee pain | |
| <input type="checkbox"/> Decreased hearing | <input type="checkbox"/> Fecal incontinence | <input type="checkbox"/> Ankle pain | <u>Hematologic</u> |
| <input type="checkbox"/> Sinus discharge | <input type="checkbox"/> Painful bowel movement | | <input type="checkbox"/> Easy bruising |
| <input type="checkbox"/> Sores in mouth | <input type="checkbox"/> Nausea/vomiting | <u>Psychologic</u> | <input type="checkbox"/> Easy bleeding |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Heartburn/reflux | <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> Poor clotting |

DO NOT WRITE BELOW:

Height: _____ ft _____ in Weight: _____ lbs HR _____ Respirations: _____ BP: _____

	WNL	Abnormalities/comments		WNL	Abnormalities/comments
Appearance			GU (males)		
HEENT			Lymph nodes		
Neck			Musculoskeletal		
Respiratory			Skin		
Cardiovascular			Neurologic		
Gastrointestinal			Psychiatric		

Special Studies

Impression

Plan

Patient Signature: _____ Date: _____ Providers Signature _____