



**New Patient Packet**

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

Sex: Male / Female Height: \_\_\_\_\_ Weight: \_\_\_\_\_

**PHYSICIAN CARE**

**Primary Care Physician:** \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Referring Physician (if different from PCP):** \_\_\_\_\_ Specialty: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PHARMACIES**

**Primary Pharmacy Type:**  Local  Mail-Order  Specialty

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PATIENT HISTORY**

**Reason for visit – Chief Complaint (History of Present Illness)**

Please describe the major problem that brings you in today to see a Neurologist:

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Date \_\_\_\_\_

**Past Medical History** Have you ever been diagnosed with any of the following medical conditions ? Please list any other conditions not listed in the space below.

YES	NO	Condition	MONTH/YEAR
		Anemia	
		Asthma	
		Arthritis, which joints mostly?	
		Atrial Fibrillation	
		Bipolar Disorder	
		Cancer, What type (s):	
		Cataracts	
		Cerebral Palsy	
		Chronic Obstructive Pulmonary Disease (COPD)	
		Chronic Kidney Disease	
		Coronary Artery (Heart) Disease	
		Congestive Heart Failure	
		Chronic Liver Failure	
		Concussion	
		Depression	
		Diabetes	
		Epilepsy / Seizures	
		Fibromyalgia	
		Glaucoma	
		Gastric Ulcers	
		Headaches / Migraines	
		High Blood Pressure	
		High Cholesterol	
		HIV	
		Lupus	
		Memory Difficulties	
		Miscarriages	
		Multiple Sclerosis	
		Myasthenia Gravis	
		Parkinson Disease	
		Stroke (Cerebrovascular Accident)	
		Spinal Cord Injury	
		Traumatic Brain Injury	
Yes	No	Other (please specify):	

Name:

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**Surgical History** Have you had any of the following surgical procedures? Please list any other surgeries not listed in the space below.

YES	NO	SURGERY TYPE	DATE/MONTH/YEAR
		Appendectomy	
		Brain Surgery	
		Breast Surgery	
		CABG (open heart surgery)	
		Colon Surgery	
		Cosmetic Surgery	
		C-Section	
		Eye Surgery	
		Fracture (bone) Surgery	
		Hernia Repair	
		Hysterectomy	
		Joint Replacement (knee, hip, etc.)	
		Small Intestine Surgery	
		Spine Surgery	
		Tubal Ligation	
		Vasectomy	
		Valve Replacement	
		Other (please specify):	

**Allergies**

Please list your Allergies and Reactions to any Foods, Drugs, Radiology Dyes, and Allergy Triggers resulting from a Chronic Condition.

*(Ex. "Allergic to: Eggs, Penicillin, Sulfas, Iodine, Local Anesthetics (Lidocaine), Latex, Contrast, Perfume, Smoke")*

*(Ex. "Reactions: Hives, Shortness of Breath, Trouble Breathing/Wheezing, and Anaphylaxis")*

Allergic to: \_\_\_\_\_ Reactions: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reactions: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reactions: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reactions: \_\_\_\_\_

Allergic to: \_\_\_\_\_ Reactions: \_\_\_\_\_

**Females:** Are you, or could you be pregnant? (Circle one) Yes / No

Last menstrual period \_\_\_\_\_ Ever use Oral Contraceptives?

Ever used Hormone Replacement Therapy? \_\_\_\_\_

Name:

DOB:

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**Social History:**

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Number of children: \_\_\_\_\_

Hobbies: \_\_\_\_\_

Do you smoke cigarettes? \_\_\_\_\_ If so, how many packs a day? \_\_\_\_\_

At what age did you start? \_\_\_\_\_ If applicable, at what age did you stop? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ If yes, how much daily? \_\_\_\_\_

At what age did you start? \_\_\_\_\_ If applicable, at what age did you stop? \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ Type? \_\_\_\_\_

Do you exercise regularly? (Circle one) No Yes How frequently? \_\_\_\_\_

**Family History:** Does anyone in your family have any of the following Medical Conditions, please indicate who.

Memory Difficulty:	NO	YES	Family Member: _____
Seizures:	NO	YES	Family Member: _____
Stroke:	NO	YES	Family Member: _____
Parkinson's disease:	NO	YES	Family Member: _____
Multiple Sclerosis:	NO	YES	Family Member: _____
Cancers:	NO	YES	Family Member: _____
			Type of Cancer: _____
Diabetes	NO	YES	Family Member: _____
Heart Disease	NO	YES	Family Member / what age: _____

Others:  Family Member: \_\_\_\_\_  
Medical Condition: \_\_\_\_\_

**Review of Symptoms/Chronic Conditions** Do you currently, or have you had a problem with:

<b>Constitutional:</b>	<b>Circle One</b>	<b>Endocrine:</b>	<b>Circle One</b>
Fever	Yes No	Diabetes	Yes No
Unexplained weight loss >10 lbs.	Yes No	Thyroid disease	Yes No
Excessive fatigue	Yes No	Excessive thirst/urination	Yes No
History of Falls	Yes No	<b>Genitourinary:</b>	
<b>Eyes:</b>		Urinary tract infections	Yes No
Wear glasses	Yes No	Painful urination	Yes No
Infections	Yes No	Blood in your urine	Yes No
Injuries	Yes No	Difficult starting/stopping stream	Yes No
<b>Ear, Nose, Throat &amp; Mouth:</b>		Incontinence	Yes No
Wear hearing aid(s)	Yes No	Kidney stones	Yes No
Hearing loss	Yes No	<b>Musculoskeletal:</b>	
Ear pain/infections	Yes No	Broken bones	Yes No
Ringing in ears	Yes No	Arm or leg weakness	Yes No
Nose bleeds	Yes No	Arm or leg pain	Yes No
Nasal congestion/drainage	Yes No	Joint pain or swelling	Yes No
Inability to smell	Yes No	<b>Integumentary:</b>	
Sinus problems	Yes No	Skin disease	Yes No
Balance (vertigo, spinning, etc.)	Yes No	Breast pain, tenderness, nipple discharge	Yes No
<b>Cardiovascular:</b>		Unusual moles-birthmarks	Yes No
Chest pain or angina	Yes No	Rash	Yes No
High blood pressure	Yes No	<b>Neurological:</b>	
Irregular pulse / Palpitations	Yes No	Fainting spells or "black outs"	Yes No
Heart murmur	Yes No	Problems with memory	Yes No
Swelling in hands or feet	Yes No	Disorientation	Yes No
Leg pain while walking	Yes No	Difficulty with speech	Yes No
<b>Respiratory:</b>		Inability to concentrate	Yes No
Shortness of breath	Yes No	Double or blurred vision	Yes No
Bloody sputum	Yes No	Weakness in arms and/or legs	Yes No
<b>Gastrointestinal:</b>		Loss of sensation	Yes No
Nausea	Yes No	Difficulty with balance	Yes No
Vomiting	Yes No	<b>Psychiatric:</b>	
Blood in your vomit	Yes No	Anxiety	Yes No
Abdominal pain	Yes No	Depression	Yes No
Change in bowel habits	Yes No	<b>Hematologic/Lymphatic:</b>	
<b>Chronic Pain:</b>		Bleeding problems	Yes No
Back Pain	Yes No	Blood transfusion	Yes No
Neck Pain	Yes No	Persistent swollen glands/lymph nodes	Yes No
Headache	Yes No	<b>Allergic/Immunologic:</b>	
Limb Pain	Yes No	Food, Inhalant (nasal) allergies	Yes No
Abdominal Pain	Yes No		
Chest Pain	Yes No		

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**Chronic Pain Patients**

Please identify any therapy treatment used in the past:

PREVIOUS TREATMENTS FOR PAIN:	TREATMENT	HELPFUL?	CURRENT/ONGOING	COMMENTS
Tens Unit?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Physical/Occupational Therapy?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	
Psychological Evaluation?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Who:
Chiropractic Treatment?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Who:
Nerve Blocks?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Who:
Epidural Injections	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Who:
Surgeries?	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	Type:	

Name:

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