

Name \_\_\_\_\_

**PLEASE BRIEFLY EXPLAIN WHY YOU ARE HERE TODAY**

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Current Primary Care Physician \_\_\_\_\_

Other Specialists you are seeing or have recently seen \_\_\_\_\_

Other Neurologists you have seen \_\_\_\_\_

**WHICH OF THE FOLLOWING ARE YOU CURRENTLY EXPERIENCING**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Fatigue                      | <input type="checkbox"/> Lethargy             | <input type="checkbox"/> Decreased Hearing R / L |
| <input type="checkbox"/> Weight Loss                  | <input type="checkbox"/> Personality Change   | <input type="checkbox"/> Swallowing              |
| <input type="checkbox"/> Fevers                       | <input type="checkbox"/> Hallucinations       | <input type="checkbox"/> Hoarseness              |
| <input type="checkbox"/> Depression                   | <input type="checkbox"/> Speech Difficulty    | <input type="checkbox"/> Choking                 |
| <input type="checkbox"/> Ear / Nose / Throat          | <input type="checkbox"/> Spells               | <input type="checkbox"/> Incontinence - Bowel    |
| <input type="checkbox"/> Cardiac Symptoms             | <input type="checkbox"/> Nausea               | <input type="checkbox"/> Incontinence - Bladder  |
| <input type="checkbox"/> Respiratory Symptoms         | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Weakness - Arms         |
| <input type="checkbox"/> Peripheral Vascular Symptoms | <input type="checkbox"/> Trouble with Smell   | <input type="checkbox"/> Weakness - Legs         |
| <input type="checkbox"/> Gastrointestinal Symptoms    | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Numbness - Arms         |
| <input type="checkbox"/> Genito-Urinary Symptoms      | <input type="checkbox"/> Double Vision        | <input type="checkbox"/> Numbness - Legs         |
| <input type="checkbox"/> Musculoskeletal Symptoms     | <input type="checkbox"/> Loss of Vision       | <input type="checkbox"/> Tingling                |
| <input type="checkbox"/> Dermatologic Symptoms        | <input type="checkbox"/> Other Visual Changes | <input type="checkbox"/> Stiffness               |
| <input type="checkbox"/> Hematologic Symptoms         | <input type="checkbox"/> Difficulty Chewing   | <input type="checkbox"/> Clumsiness              |
| <input type="checkbox"/> Headache                     | <input type="checkbox"/> Facial Numbness      | <input type="checkbox"/> Pain                    |
| <input type="checkbox"/> Dizziness                    | <input type="checkbox"/> Facial Tingling      | <input type="checkbox"/> Poor Balance            |
| <input type="checkbox"/> Fainting                     | <input type="checkbox"/> Drooling             | <input type="checkbox"/> Poor Coordination       |
| <input type="checkbox"/> Confusion                    | <input type="checkbox"/> Difficulty Tasting   | <input type="checkbox"/> Trouble Walking         |
| <input type="checkbox"/> Memory                       | <input type="checkbox"/> Tinnitus             | <input type="checkbox"/> Sleeping Problems       |
| <input type="checkbox"/> Concentration                | <input type="checkbox"/> Vertigo              | <input type="checkbox"/> Snoring                 |

**CURRENT MEDICATIONS**

Start Date

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Name \_\_\_\_\_

### SOCIAL HISTORY

How much alcohol do you drink? \_\_\_\_\_

Do you smoke? \_\_\_\_\_ Did you ever? \_\_\_\_\_

Do you now or did you ever use drugs? \_\_\_\_\_

What is your occupation? \_\_\_\_\_

What is the highest grade you went to in school? \_\_\_\_\_

Do you live alone? \_\_\_\_\_

How many children do you have? \_\_\_\_\_ (ages) \_\_\_\_\_

How many caffeinated beverages (cola, coffee, tea) per day? \_\_\_\_\_

Are you currently experiencing any unusual stress? \_\_\_\_\_

### DRUG ALLERGIES

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PAST MEDICAL HISTORY

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Headache                  | <input type="checkbox"/> Colonic Polyps                        | <input type="checkbox"/> Menstrual / Hormone Disturbances |
| <input type="checkbox"/> Epilepsy / Seizures       | <input type="checkbox"/> Bleeding Disorder / Clotting Disorder | <input type="checkbox"/> Sexual Dysfunction               |
| <input type="checkbox"/> Stroke                    | <input type="checkbox"/> Anemia                                | <input type="checkbox"/> High Cholesterol                 |
| <input type="checkbox"/> Head Injury               | <input type="checkbox"/> Diabetes                              | <input type="checkbox"/> Kidney Disease                   |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> Peripheral Vascular Disease           | <input type="checkbox"/> Genito-Urinary Disease           |
| <input type="checkbox"/> Coronary Artery Disease   | <input type="checkbox"/> Hypothyroidism                        | <input type="checkbox"/> Venereal Disease, type: _____    |
| <input type="checkbox"/> Heart Attack              | <input type="checkbox"/> Hyperthyroidism                       | <input type="checkbox"/> Arthritis                        |
| <input type="checkbox"/> Allergy / Hay Fever       | <input type="checkbox"/> Reflux / GERD                         | <input type="checkbox"/> Cancer, type: _____              |
| <input type="checkbox"/> Liver Disease / Hepatitis | <input type="checkbox"/> Irritable Bowel Syndrome              | <input type="checkbox"/> Tuberculosis                     |
| <input type="checkbox"/> Heart Arrhythmia          | <input type="checkbox"/> Menopause                             | <input type="checkbox"/> HIV                              |
| <input type="checkbox"/> High Blood Pressure       | <input type="checkbox"/> Fibromyalgia                          | <input type="checkbox"/> Polio                            |
| <input type="checkbox"/> Emphysema / COPD          | <input type="checkbox"/> Bipolar Disorder                      |   |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Osteoporosis                          |   |
| <input type="checkbox"/> Peptic Ulcer Disease      |  |   |

### PRIOR SURGERIES / HOSPITALIZATION

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Pregnant Now?  Yes  No

