INITIAL PATIENT
NEUROLOGICAL/NEUROSURGICAL EVALUATION

Please fill out pages 1 through 4 completely.

Chart No:_____ Male Female Age_____
Patient's Name:_____ Right Left Handed
Date of Visit:_____

Physician Requesting Consultation:
Primary Care M.D.:

- **Chief Complaint** (Reason you are here): _____

History of Present Illness

- **L** Where are you having pain or unusual symptoms (for example head, neck, back, etc)? _____
  _____
  (location of symptoms/complaints)
- **D** When did these symptoms start? _____
  (Please specify)
- **C** Are your complaints due to / associated with an accident, injury, or recent illness? No Yes (circle one)
  If yes, please specify _____
- **Q** Describe the type of discomfort you are having (for example; burning pain, tingling, aching, etc.) _____
  _____
- **S** Are the symptoms MILD, MODERATE, SEVERE in intensity? (circle one)
- **T** Are the symptoms CONSTANT, or VARIABLE (circle one). If VARIABLE, please specify
  _____
  _____
- **M** Does anything you do make the symptoms BETTER? No Yes (circle one)
  If Yes, please specify _____

  Does anything you do make the symptoms WORSE? No Yes (circle one)
  If yes, Please specify _____
- **A** Are the main symptoms you are having associated with any other minor symptoms that you are aware of?
  No Yes If yes, please specify _____

  ADDITIONAL INFORMATION (Physician use only) _____

  _____

  _____

  _____

History Taken / Reviewed By _____MD
Physician Signature

NEW PATIENT INFORMATION

Patient Name:_____ Chart No:_____
Date of Visit:_____

1. What problem brought you to our group of doctors? _____
_____
2. Is this problem due to an accident? _____No _____Yes Date of Accident _____
3. Is this accident work related? _____No _____Yes _____N/A
4. What tests have been done to evaluate this problem? _____
5. Which Physicians have seen you for this problem? _____

REVIEW OF SYSTEMS

Please CIRCLE any symptoms you are CURRENTLY having. If none write "NONE".

- **CONSTITUTIONAL:** Fever, Fatigue, Weight Loss or Gain, Other _____
- **EYES, EARS, NOSE, THROAT:** Hearing Loss, Ringing in Ears, Visual Loss, Double Vision, Allergies, Sinus Trouble, Nose Bleeds, Sore Throat, Other _____
- **CARDIOVASCULAR:** Heart Symptoms, Chest Pain, Irregular Heart Beat, Shortness of Breath
  Other _____
- **RESPIRATORY:** Shortness of Breath, Coughing up Blood or Sputum, Wheezing. _____
  Other _____
- **GASTROINTESTINAL:** Trouble Swallowing, Heartburn, Appetite Loss, Nausea, Vomiting, Diarrhea, Abdominal Pain, Constipation, Blood in Bowel Movement, Other _____
- **HEMATOLOGICAL/LYMPHATIC:** Anemia, Easy Bruising, Spontaneous Bleeding, History of Prior Blood Transfusion,
  Other _____
- **GENITAL/URINARY**: Frequency or Pain with Urination, Difficulty Passing Urine, Blood in Urine, Sexual Dysfunction,
  Abnormal Menstrual Periods, Testicular Pain or Masses, Sexually Transmitted Diseases
  Other _____
- **PSYCHIATRIC:** Nervousness, Tension, Mood Swings, Depression, Other _____
- **ENDOCRINE:** Excessive Thirst, Excessive Urination, Sweating or Weight Loss _____
- **NEUROLOGICAL:** Fainting, Blackout Spells, Seizures, Paralysis of Limbs, Speech Difficulty, Memory Loss, Pain or Numbness of Spine, Arms, or Legs, Other _____
- **MUSCULOSKELETAL:** Cramping, Weakness, Fatigue of Muscles or Change in size of muscle, Joint pain or Inflammation,
  Other _____
- **ALLERGIC/IMMUNOLOGIC:** Reactions to food, Medication, Frequent colds or Other Illnesses,
  Other _____
- **INTEGUMENTARY (SKIN):** Skin rashes, Skin Masses, Itching, Other _____

Reviewed By _____MD
Physician Signature

PAST MEDICAL, FAMILY AND SOCIAL HISTORY

Patient Name: _____ Chart Number:_____
Date of Visit:_____

- **PAST HISTORY**

Surgical: List all prior surgeries/serious injuries and date of occurrence.

1. _____ 4._____

2. _____ 5. _____

3. _____ 6. _____

Other: _____

PAST/CURRENT MEDICAL PROBLEMS

	Yes	No
1. Cancer (Specify Type) _____……..	_____	_____
2. Diabetes: Diet Controlled, Oral Medications, Insulin Dependent (Circle One)…….	_____	_____
3. High Blood Pressure……..……..	_____	_____
4. Heart Disease (Prior Heart Attach, Pacemaker, Other _____)…….	_____	_____
5. Seizure…….	_____	_____
6. Stomach Ulcers……	_____	_____
7. Breathing Problems……..	_____	_____
8. Bowel/Bladder Problems…….	_____	_____
9. Stroke……	_____	_____
10. Ears, Eyes, Nose, Throat…….	_____	_____
11. Thyroid Hypo Hyper (Circle One)……..	_____	_____
12. Other Medical Problems……..	_____	_____

13. Number of Pregnancies_____Number of Live Births_____ Number of Miscarriages_____

Allergies: Dust, Pollen, Animals _____Foods _____ _____ _____

To Medications_____ _____ _____ _____
(Medication) (Reaction)

Current Medication (Please list on this form)

	Medication	Strength	How Often Taken
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____
7.	_____	_____	_____
8.	_____	_____	_____
9. Other Medications	_____	_____	_____

Reviewed By _____MD
Physician Signature

- **FAMILY HISTORY:** Please list major medical problems and/or causes of death in your immediate family.
  If none write "NONE".

Father	Mother	Children	Siblings	Grandparents
1. _____	1. _____	1. _____	1. _____	1. _____
2. _____	2. _____	2. _____	2. _____	2. _____
3. _____	3. _____	3. _____	3. _____	3. _____
4. _____	4. _____	4. _____	4. _____	4. _____

- **SOCIAL HISTORY**

Marital Status: (Circle One) Single Married Divorced Widowed

Occupation: _____

Employer:_____

Highest level of education you have obtained: _____

Tobacco Use: _____Never

_____ Previously

How long did you smoke? _____

What form of tobacco? _____

When did you stop using tobacco? _____

_____Yes

How long have you smoked? _____

What form of tobacco do you use? _____

How much do you smoke (pack/day, etc)? _____

Alcohol Use: _____Never

_____Occasional/Social Use

_____Other _____

Have you ever been treated for any type of alcohol or drug abuse dependency?

_____No

_____Yes (Please specify) _____

_____

I certify that the CHIEF COM PLAINT, HISTORY OF PRESENT ILLNESS, FAMILY HISTORY AND SOCIAL HISTORY is accurate to the best of my knowledge.

_____**Date:**_____

Your Signature **Date of Visit**