Kalamazoo Nerve Center, PLLC

Neurology History

Current Date: 10/17/11

Last Name: _____ First Name: _____ Initial: _____ DOB: _____

Referring Physician: _____ Primary Care Physician: _____

What hand do you use on a regular basis? ☐ Right ☐ Left ☐ Ambidextrous

1. Describe in detail the reason you are here to see the Neurologist today.

   a. Please describe symptoms for which you're being seen today.

   b. When did this problem start? (please list date)

   c. Is there anything that triggered this problem?

   d. Does anything make this problem better?

2. Describe any of the following treatments you have tried, for how long and if they worked or not.

   a. Medications:

   b. Physical Therapy:

   c. Surgery:

   d. Other (e.g. chiropractic):

3. What tests have been done up to this date? (e.g. Blood tests, MRI,CT, EMG, EEG)

4. Have you seen a neurologist before for this problem? If yes, please list the following:

   Name: _____ Location: _____

   Date(s) you saw this doctor: _____

   Name: _____ Location: _____

   Date(s) you saw this doctor: _____

FAMILY HISTORY: Do you have any family members with similar symptoms/disorders? If yes, please list the following:

Relationship: _____ Age: ____ Problem: _____

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PAST MEDICAL HISTORY: (Please check if you have ever had any of the following):

☐ Vision loss ☐ Seizures ☐ Loss of consciousness ☐ Stroke ☐ TIA (stroke that went away) ☐ Multiple sclerosis

☐ Optic Neuritis ☐ Brain aneurysm ☐ Bleeding in/around the brain ☐ Meningitis ☐ Carotid stenosis ☐ Neuropathy

☐ Head injury ☐ Parkinson's ☐ Tremors ☐ Sleep disorders ☐ Muscle diseases ☐ Genetic (inherited) neurologic disease

Please describe any other neurological disorder that was not listed above:

OTHER PAST MEDICAL HISTORY: Please check if you have or had:

☐ Medical problems you were born with (describe):

☐ Heart disease ☐ High blood pressure ☐ High cholesterol ☐ Atrial fibrillation ☐ Clogged arteries (peripheral vascular disease)

☐ Cancer (please give type and date of diagnosis) _____

Infections: ☐ Meningitis ☐ Encephalitis ☐ Genital herpes ☐ Shingles

Childhood infections: ☐ Measles ☐ Mumps ☐ Chicken pox ☐ Rheumatic fever

Immunizations: ☐ Polio ☐ Shingles ☐ Tetanus Date _____

Degenerative diseases: ☐ Arthritis ☐ Lupus ☐ Other (describe) _____

Surgical operations: _____

Any Injuries, car accidents or broken bones?: (describe and give date) _____

Have you been hospitalized for any reason? ☐ Yes ☐ No (describe) _____

Have you been treated for depression, anxiety or chemical dependency issues? (describe and give date) _____

Patient Name & DOB _____

SOCIAL HISTORY : Marital status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Number of children and their ages: _____

Current Occupation: _____ Education-Grade completed/ Degree? _____

Have you ever or do you currently smoke or chew tobacco? ☐ Yes ☐ No

How much per day? _____ Start date: _____ Quit date: _____

How much alcohol do you drink per week? _____

Have you ever used street drugs or drugs not prescribed to you? _____

What are your significant hobbies or interests? _____

CURRENT MEDICATIONS: Please list all the prescription medications, vitamins, other supplements and herbal medications you take now.

	Medication	Dose	How often
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

ALLERGIES OR REACTIONS TO MEDICATIONS:

	Medication	Reaction
1.		
2.		
3.		
4.		
5.		

Review of Systems: Please check all problems you have now or had recently

General ☐ Fevers ☐ Chills ☐ Sweats ☐ Appetite loss ☐ Weight loss ☐ Weight gain ☐ Fatigue

Eyes ☐ Dry eyes ☐ Double vision ☐ Blurred vision ☐ Eye irritation ☐ Eye pain ☐ Discharge ☐ Light sensitivity ☐ Decreased vision

ENMT ☐ Earache ☐ Ear discharge ☐ Ringing in the ears ☐ Decreased hearing ☐ Nasal congestion ☐ Nose bleeds ☐ Sinus problems ☐ Bleeding gums ☐ Difficulty swallowing ☐ Dry mouth ☐ Hoarseness ☐ Sore throat

Cardiovascular ☐ Difficulty breathing at night ☐ Chest pain or discomfort ☐ Irregular heartbeats ☐ Palpitations ☐ Lightheadedness ☐ Shortness of breath with exertion ☐ Difficulty breathing while lying down ☐ Leg cramps with exertion ☐ Swelling of hands or feet ☐ Discoloration of lips or nails

Respitory ☐ Sleep disturbances due to breathing ☐ Cough ☐ Coughing up blood ☐ Shortness of breath ☐ Wheezing ☐ Painful breathing ☐ Chest discomfort ☐ Excessive sputum ☐ Excessive snoring

Gastroentestinal ☐ Change in appetite ☐ Indigestion ☐ Heartburn ☐ Nausea ☐ Vomiting ☐ Excessive gas ☐ Abdominal pain ☐ Hemorrhoids ☐ Diarrhea ☐ Change in bowel habits ☐ Constipation ☐ Bloody stools ☐ Black or tarry stools

Genitourinary ☐ Frequent urination ☐ Blood in urine ☐ Foul urinary discharge ☐ Urinary urgency ☐ Trouble starting urinary stream ☐ Inability to empty bladder ☐ Burning or pain on urination ☐ Genital rashes or sores ☐ Inability to control bladder

Genitourinary Female ☐ Unusual urinary color ☐ Missed periods ☐ Excessively heavy periods ☐ Pelvic pain

Musculoskeletal ☐ Joint pain ☐ Neck pain ☐ Back pain ☐ Muscle aches ☐ Loss of strength ☐ Arthritis

Skin ☐ Suspicious lesions ☐ Night sweats ☐ New lumps or bumps ☐ Poor wound healing ☐ Dryness ☐ Itching ☐ Rash ☐ Sores ☐ Flushing ☐ Changes in hair or nails ☐ Unusual spots or patches of color ☐ Changes in color of skin ☐ Skin cancer ☐ Melanoma ☐ Changes in skin appearance that comes and goes

Neurologic ☐ Headaches ☐ Difficulty with speaking ☐ Difficulty with concentration ☐ Getting lost frequently ☐ Falls ☐ Disturbances in coordination ☐ Weakness ☐ Brief paralysis ☐ Numbness ☐ Tingling ☐ Faints or blackouts ☐ Seizures ☐ Tremors ☐ Sensation of room spinning ☐ Memory loss ☐ Excessive daytime sleeping ☐ Word finding difficulty ☐ Difficulty chewing or swallowing ☐ Change in taste sensation ☐ Muscle spasms ☐ Muscle stiffness ☐ Poor balance

Psychiatric ☐ Anxiety ☐ Nervousness ☐ Depression ☐ Frightening visions or sounds ☐ Hallucinations

Endocrine ☐ Heat or cold intolerance ☐ Weight change ☐ Excessive sweating ☐ Hypertension

Hematologic-Lymphatic ☐ Bleeding ☐ Enlarged lymph nodes ☐ Abnormal bruising

Allergic-Immunologic ☐ Seasonal allergies ☐ Hives or rash ☐ HIV exposure

☐ Other:

Patient Signature: _____ Date of Birth:_____ Date completed:_____

Guardian/Personal Representative: _____
(Sign and state relationship to patient)