PROGRESSIVE NEUROLOGY

Name: _____

DOB: _____ **Age:** _____

Gender: ☐ Male ☐ Female

Appointment Date: _____

Patient Form - First Visit

Handedness: ☐ Right ☐ Left ☐ Both ☐ Unknown

Allergies: _____

Developmental and Neurological History: (Check all that applies and describe)

- ☐ Problems during your mother's pregnancy _____
- ☐ Problems during your birth _____
- ☐ Problems immediately after you were born _____
- ☐ Delay in language / motor development _____
- ☐ Learning disability _____
- ☐ Meningitis / Encephalitis _____
- ☐ Convulsions with fevers _____
- ☐ Severe head trauma _____
  - ☐ With loss of consciousness _____
- ☐ Brain surgery _____
- ☐ Stroke _____

Past Medical / Surgical History: (Check all that applies and describe)

☐ High Blood Pressure	☐ Parkinson's	☐ Dialysis	☐ Appendix	☐ C-Section	☐ Sleep Apnea
☐ Heart Disease	☐ Migraine	☐ Kidney Disease	☐ Gall Bladder	☐ Hysterectomy	☐ Asthma
☐ Pacemaker	☐ Depression	☐ Kidney Stones	☐ Hernia	☐ Breast Surgery	☐ Emphysema
☐ Diabetes	☐ Seizures	☐ Liver Disease	☐ Ulcer	☐ Miscarriages	☐ Cancer

☐ Other / Describe: _____

Social History:

Tobacco: ☐ Yes ☐ No How much: _____

Alcohol: ☐ Yes ☐ No How much: _____

Drugs: ☐ Yes ☐ No Specify: _____

Driving: ☐ Yes ☐ No

Student: ☐ Full-time ☐ Part-time ☐ None

Job: ☐ Full-time ☐ Part-time ☐ Retired ☐ Disabled

Education: _____

Profession: _____

Marital Status: ☐ Single ☐ Married ☐ Separated / Divorced ☐ Widowed

Children: ☐ Yes ☐ No How many: _____

Planning Pregnancy: ☐ Yes ☐ No

Diet: ☐ Regular ☐ Restrictions: _____

Family History: (Indicate diseases present in you family. F: Father, M: Mother, S: Sister, B: Brother, C: Cousin, O: Other)

____High Blood Pressure	____Cholesterol	____Kidney Stones	____Stroke	____Brain Surgery
____Heart Disease	____Cancer	____Depression	____Seizures	____Migraine
____Diabetes	____Liver Disease	____Dementia	____Parkinson's	____Other

Medications: (List all medications, including over the counter supplements)

Medication	Morning	Noon	Afternoon	Evening

Previous Testing:

Test	When and Where?
☐ MRI	_____
☐ CT Scan	_____
☐ PET Scan	_____
☐ SPECT Scan	_____
☐ EEG	_____
☐ Video-EEG	_____
☐ Home-EEG	_____
☐ Other Tests	_____

Review of Systems: (Check all that applies)

General Health
- __ fatigue
- __ fevers
- __ night sweats
- __ weight gain
- __ weight loss

Visual System
- __ blurred vision
- __ double vision
- __ decreased vision
- __ eye pain
- __ eye redness
- __ visual loss

Head and Neck
- __ hearing loss
- __ ringing
- __ dizziness
- __ nasal congestion
- __ neck pain
- __ neck stiffness
- __ seasonal allergies
- __ sinus pain

Gastrointestinal
- __ belly pain
- __ diarrhea
- __ constipation
- __ loss of appetite
- __ black stools
- __ blood in stool
- __ nausea
- __ vomiting

Respiratory
- __ chronic cough
- __ shortness of breath
- __ coughing blood

Cardiovascular
- __ chest pain
- __ ankle swelling
- __ palpitations

Musculoskeletal
- __ joint pain
- __ joint swelling
- __ joint stiffness
- __ muscle pain

Skin
- __ large moles
- __ rash
- __ Hair Loss

Genitourinary
- __ blood in urine
- __ difficulty urinating
- __ pain during urination
- __ trouble holding urine
- __ waking up to urinate
- __ erectile dysfunction
- __ PMS

Psychiatric
- __ anxiety
- __ depression
- __ panic attacks
- __ irritability
- __ inner sadness
- __ loss of pleasures
- __ hallucinations
- __ aggression
- __ restlessness

Sleep
- __ daytime sleepiness
- __ daytime fatigue
- __ frequent awakenings
- __ difficulty falling asleep
- __ difficulty staying asleep
- __ snoring
- __ leg movements in sleep
- __ restless legs
- __ sleep talking
- __ sleep walking

Neurological
- __ headache
- __ trouble walking
- __ poor balance
- __ poor coordination
- __ memory difficulties
- __ concentration problems
- __ difficulty finding words
- __ difficulty speaking
- __ numbness
- __ tingling
- __ weakness
- __ shaky hands

List other symptoms: _____

Questions and Concerns:

_____

_____

_____

Name: _____ **Signature:** _____ **Date:** _____