COLLIER NEUROLOGIC SPECIALISTS

Name:_____ Date: _____

Date of birth: _____ How old are you?_____ Dominant hand (circle one): Right Left

Referring physician:_____ Primary Care Physician:_____

Reason for visit:_____ How long? _____

Have you had any of the following treatments:
_____ pain medication?
_____ epidural injections?
_____ physical therapy?
_____ surgery?

Do not write in area below:

Please list current **MEDICATIONS**: _____

_____

Pharmacy Name, phone, address:_____

Do you have any **ALLERGIES** to medications? **No** **Yes** If yes, what medicine and kind of reaction?

_____

Please list any **SURGERIES** (including cosmetic surgery) or **HOSPITAL ADMISSIONS** and dates.

_____

_____

_____

Social History:

Do you drink alcohol?	**No**	**Yes**	If yes, how much and how often? _____
Have you ever smoked?	**No**	**Yes**	If yes, how much? _____ How long?_____
Have you quit?	**No**	**Yes**	When did you stop?_____
Do you have any children?	**No**	**Yes**	If yes, how many?_____
Do you live alone?	**No**	**Yes**	If no, with whom? _____
Are you retired?	**No**	**Yes**	Occupation (or former occupation): _____

Family History:

Mother	Living	Deceased	Cause of death: _____ Age _____
Father	Living	Deceased	Cause of death: _____ Age _____
Brother/Sister	Living	Deceased	Cause of death: _____ Age _____
Brother/Sister	Living	Deceased	Cause of death: _____ Age_____
Brother/Sister	Living	Deceased	Cause of death: _____ Age _____
Brother/Sister	Living	Deceased	Cause of death: _____ Age_____

Please list any diseases that run in your family:_____

TURN PAGE OVER

Please check [√] any **medical conditions** listed below that you have been diagnosed to have:

___ high blood pressure
___ heart disease/angina/heart attack
___ irregular heartbeat
___ high cholesterol
___ ear/nose/throat problems
___ COPD/emphysema/asthma
___ other (please list)_____

___ bowel or bladder problems
___ stomach ulcers
___ prostate problems
___ kidney stones
___ diabetes
___ thyroid problems

___ arthritis/gout
___ stroke
___ polio
___ blood clots
___ anemia
___ cancer (type)_____

Please check [√] any **current problems** you may have: (Review of Systems)

Constitutional
___ Weight loss
___ Fever
___ Poor sleep

Eyes
___ Blurred vision
___ Loss of vision
___ Double vision
___ Eye pain

Ears/Nose/Throat
___ Difficulty swallowing
___ Decreased hearing
___ Sinus discharge
___ Sores in mouth
___ Ear pain

Cardiovascular
___ Chest pain
___ Palpitations

Respiratory
___ Shortness of breath
___ Cough
___ Sputum

Gastrointestinal
___Diarrhea
___ Constipation
___ Blood in stool
___ Fecal incontinence
___ Painful bowel movement
___ Nausea/vomiting
___ Heartburn/reflux

Genitourinary
___ Blood in urine
___ Urinary frequency
___ Urinary incontinence

Musculoskeletal
___ Muscle pain
___ Hand joint pain
___ Wrist pain
___ Elbow pain
___ Shoulder pain
___ Hip pain
___ Knee pain
___ Ankle pain

Psychologic
___ Depression/anxiety

Neurologic
___ Slurred speech
___ Vertigo/dizziness
___ Memory loss
___ Focal weakness
___ Focal numbness
___ Problems walking

Skin
___ Moles changing
___ Rash
___ Poor healing

Hematologic
___ Easy bruising
___ Easy bleeding
___ Poor clotting

Patient Signature: _____ **Date**: _____

----------DO NOT WRITE BELOW----------

Height: _____ ft _____ in Weight: _____ lbs HR _____ Respirations: _____ BP: _____

	WNL	Abnormalities/comments		WNL	Abnormalities/comments
Appearance			GU (males)		
HEENT			Lymph nodes		
Neck			Musculoskeletal		
Respiratory			Skin		
Cardiovascular			Neurologic		
Gastrointestinal			Psychiatric		

Special Studies

Impression

Plan

Providers Signature:_____