G. Gary Lian, M.D., Ph.D., Shoreline Neurology, LLC

Patient Name: _____ Date of Birth: _____ Date: _____

Welcome to our practice. As a new patient, we will discuss your health in detail. To help us in these discussions, please fill out the information below to the best of your ability.

Reason for visit: _____
_____
_____

History of present illness:

Location _____ Quality _____
(Where is the pain/problem?) (Normal versus abnormal, color, activity, etc)

Severity _____ Duration _____
(A scale of 1-5, 5 being the most severe) (How long have you had this pain/problem?)

Timing _____ Context _____
(Does this pain/problem occur at a specific time?) (Where were you at the onset of pain/problem?)

Associated Symptoms _____ Modifying Factors _____
(What other problems have you been having?) (What makes the pain/problem worse or better?)

Current Medications: **Dose** **Duration**

_____
_____
_____
_____
_____
_____
_____
_____

Medical History:

Headache/Migraine	Y N	Congestive heart failure	Y N	Liver disease/Hepatitis	Y N
Headache/Tension	Y N	Heart murmur	Y N	Renal Disease	Y N
Epilepsy/Seizures	Y N	Hypertension	Y N	Genitourinary disease	Y N
Stroke (CVA)	Y N	COPD	Y N	Venereal disease	Y N
Neuromuscular disease	Y N	Pneumonia	Y N	Arthritis	Y N
Head injury	Y N	Asthma	Y N	Cancer	Y N
Spinal cord injury	Y N	Peptic ulcer disease	Y N	Tuberculosis	Y N
Cervical spine disease	Y N	Colonic polyps	Y N	HIV	Y N
Lumbar spine disease	Y N	Bleeding disorder	Y N	Exposures	Y N
Peripheral nerve disease	Y N	Anemia	Y N	Mumps	Y N
Brain/spine tumors	Y N	Diabetes	Y N	Measles	Y N
Depression	Y N	Peripheral vascular disease	Y N	Polio	Y N
Coronary artery disease	Y N	Thyroid disease	Y N	Rheumatic fever	Y N
Myocardial infarction	Y N	Menstrual/sexual dysfunction	Y N	Allergy/Hey Fever	Y N
Cardiac arrhythmias	Y N	Other endocrine disease	Y N	Other-Specify _____	Y N

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Patient Name: _____ Date of Birth: _____ Date: _____

Prior surgeries/Hospitalizations:

_____
_____
_____

Drug allergies/Other allergies:

_____
_____
_____

Family History:

	Father	*Mother*	*Father's Parents*	*Mother's Parents*	*Siblings*	*Children*
Heart disease	□	□	□	□	□	□
Hypertension	□	□	□	□	□	□
Diabetes	□	□	□	□	□	□
Cancer	□	□	□	□	□	□
Arthritis	□	□	□	□	□	□
Bleeding disorder	□	□	□	□	□	□
Kidney disorder	□	□	□	□	□	□
Thyroid disease	□	□	□	□	□	□
Brain/Spine tumor	□	□	□	□	□	□
Epilepsy	□	□	□	□	□	□
Stroke	□	□	□	□	□	□
Mental Illness	□	□	□	□	□	□
Dementia	□	□	□	□	□	□
Neuromuscular	□	□	□	□	□	□
Age of death	□	□	□	□	□	□
Other _____	□	□	□	□	□	□

Social History:

Occupation: _____ Education: _____

Marital Status: _____ Number of Children: _____ Pregnant now? Yes No

Smoking: _____ pack/day, _____ years; Quit _____ years. Drug use: _____

Alcohol: □ Social drink; or _____ drinks/day, _____ years; Quit _____ years.