

# QUALITY NEUROLOGY

**Patient's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_ **Social Security #:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, State, Zip:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_ **Mobile:** \_\_\_\_\_

**Would you like to receive text messages for reminders/updates?** ☐ Yes ☐ No

**Preferred method of contact?** ☐ Home Phone ☐ Mobile ☐ Email

**Email Address:** \_\_\_\_\_

**Gender:** ☐ Male ☐ Female ☐ Other ☐ Choose not to disclose

**Race:** ☐ Asian ☐ Black/African American ☐ White ☐ Other ☐ Choose not to disclose

**Ethnicity:** ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Other ☐ Choose not to disclose

**Preferred language?** \_\_\_\_\_

**Who referred you to us?** \_\_\_\_\_

**Who is your primary care provider?** \_\_\_\_\_

**Other physicians, including your neurologist, who should receive correspondence regarding your care:**

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**For what problem were you referred today?** \_\_\_\_\_

**Preferred Pharmacy:** \_\_\_\_\_

**Preferred Lab:** \_\_\_\_\_

**Preferred Imaging Facility:** ☐ Invision ☐ Titan ☐ Other: \_\_\_\_\_

**Any recent imaging? If so, what and where?:** \_\_\_\_\_

**LIST CURRENT MEDICATIONS:**

Drug Name	Dose	Frequency

**REVIEW OF SYSTEMS: Circle all that apply**

Vision Changes

Loss of Smell

Sinus Problems

Difficulty Hearing

Chest Pain

Palpitations

Cough

Constipation

Incontinence

ED

Muscle Aches

Dizziness

Joint Pain

Neck Pain

Weakness

Headaches/Migraines

Seizures

Tremor

Memory Loss

Forgetfulness

Depression

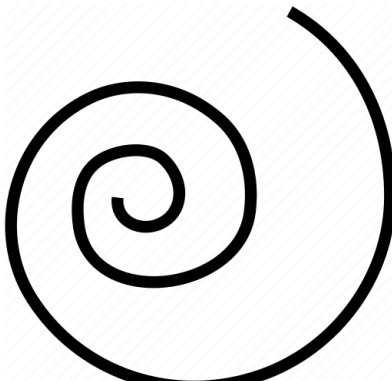
Anxiety

Poor Sleep/Restless Sleep

Fatigue

Falls (How many \_\_\_\_\_)

Personality Changes

Your Medical History	Surgeries/Operations	Family history
<p><b>Have you had any of the following? If yes, please write a check mark.</b></p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> High Blood Pressure</p> <p><input type="checkbox"/> Heart Attack</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Heart Stent</p> <p><input type="checkbox"/> Atrial Fibrillation (AFib)</p>	<p><b>Have you had surgery on any of the following areas?</b></p> <p style="text-align: right;">Year and Reason</p> <p><input type="checkbox"/> Brain _____</p> <p><input type="checkbox"/> Back _____</p> <p><input type="checkbox"/> Breast _____</p> <p><input type="checkbox"/> Cataract _____</p> <p><input type="checkbox"/> Gastric bypass _____</p> <p><input type="checkbox"/> Spine _____</p> <p><input type="checkbox"/> Other (please explain) _____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><b>Has any blood relative had any of the following? <u>Unknown</u> <u>Adopted</u></b></p> <p style="text-align: right;">Relationship</p> <p><input type="checkbox"/> Alcoholism _____</p> <p><input type="checkbox"/> Aneurysm _____</p> <p><input type="checkbox"/> Cancer _____</p> <p><input type="checkbox"/> Depression _____</p> <p><input type="checkbox"/> Dementia _____</p> <p><input type="checkbox"/> Diabetes _____</p> <p><input type="checkbox"/> Early Death _____</p> <p><input type="checkbox"/> Heart disease _____</p> <p><input type="checkbox"/> High blood pressure _____</p> <p><input type="checkbox"/> Kidney disorder _____</p> <p><input type="checkbox"/> Mental illness _____</p> <p><input type="checkbox"/> Multiple Sclerosis _____</p> <p><input type="checkbox"/> Migraines _____</p> <p><input type="checkbox"/> Parkinson's _____</p> <p><input type="checkbox"/> Seizure(s) _____</p> <p><input type="checkbox"/> Stroke _____</p> <p><input type="checkbox"/> Substance abuse _____</p> <p><input type="checkbox"/> Suicide _____</p> <p><input type="checkbox"/> Thyroid disorder _____</p> <p><input type="checkbox"/> Other (please explain) _____</p> <p>_____</p> <p>_____</p>
<p style="text-align: center;"><b>Misc</b></p> <p>Who do you live with?</p> <p>_____</p> <p>Are you retired? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>What is/was your occupation?</p> <p>_____</p>	<p style="text-align: center;"><b>Social history</b></p> <p>Alcohol use? <input type="checkbox"/> yes <input type="checkbox"/> no <input type="checkbox"/> social</p> <p>Tobacco use?</p> <p><input type="checkbox"/> current <input type="checkbox"/> former <input type="checkbox"/> never</p>	<p><b>Please draw a line starting from the center and spiral out.</b></p> <div style="text-align: center;">  </div>
<p>Handedness: (circle)</p> <p>Right</p> <p>Left</p> <p>Ambidextrous</p> <p>Do you have a living will?</p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p style="text-align: center;"><b>Hospitalization</b></p> <p>Please list any hospitalizations and location?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p style="text-align: center;"><b>Please list any medication allergies and reactions.</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	

## Patient Health Questionnaire (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Please circle your answer)

	<b>NOT AT All</b>	<b>SEVERAL DAYS</b>	<b>MORE THAN HALF THE DAYS</b>	<b>NEARLY EVERY DAY</b>
1 Little interest or pleasure in doing things	0	1	2	3
2 Feeling down, depressed, or hopeless	0	1	2	3
3 Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4 Feeling tired or having little energy	0	1	2	3
5 Poor appetite or overeating	0	1	2	3
6 Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	2	3
7 Trouble concentrating on things, such as reading or watching television	0	1	2	3
8 Moving or speaking so slowly that other people could have noticed. OR the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9 Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3