

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:

For what problem were you referred today? _____

Preferred Pharmacy: _____

Preferred Lab: _____

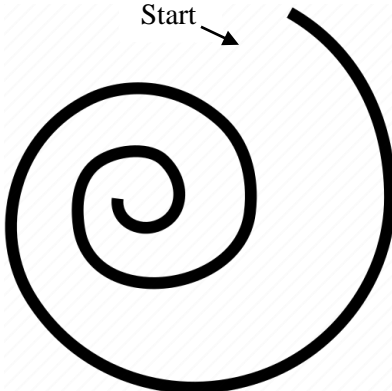
Preferred Imaging Facility: Invision Titan Other: _____

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
- Personality Changes

Your Medical History	Surgeries/Operations	Family history
<p>Have you had any of the following? If yes, please write a check mark</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 Condition</p> <p><input type="checkbox"/> Obesity</p> <p><input type="checkbox"/> Seizure</p> <p><input type="checkbox"/> Stroke</p> <p style="text-align: center;">Misc</p> <p>Who do you live with? _____</p> <p>What is/was your occupation? _____</p> <p>Are you retired? <input type="checkbox"/>yes <input type="checkbox"/>no</p> <p>Handedness: (circle)</p> <p>Right</p> <p>Left</p> <p>Ambidextrous</p> <p>Do you have a living will? <input type="checkbox"/> yes <input type="checkbox"/>no</p> <p style="text-align: center;">Hospitalization</p> <p>Please list any hospitalizations and location?</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Have you had surgery on any of the following areas?</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 style="text-align: center;">Social history</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 style="text-align: center;">Please list any medication allergies and reactions.</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Has any blood relative had any of the following? <u>Unknown</u> <u>Adopted</u></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;">Please draw a line around to the center.</p> <div style="text-align: center;">  </div>

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)

	NOT AT All	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
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