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 (How many _____)
Personality Changes

Your Medical History

Have you had any of the following? If yes, please write a check mark

__Cancer
__Depression
__Diabetes
__High Blood Pressure
__Heart Condition
__Obesity
__Seizure
__Stroke

Misc

Who do you live with**?**

_____

What is/was your occupation?

_____

Are you retired? __yes __no

Handedness: (circle)
Right
Left
Ambidextrous

Do you have a living will?
__ yes __no

Hospitalization

Please list any hospitalizations and location?

_____
_____
_____
_____
_____
_____

Surgeries/Operations

Have you had surgery on any of the following areas?

Year and Reason

__Brain _____
__Back _____
__Breast _____
__Cataract _____
__Gastric bypass _____
__Spine _____
__Other (please explain) _____
_____
_____
_____
_____
_____

Social history

Alcohol use? __ yes __no __ social
Tobacco use?
__ current __ former ___ never

Please list any medication allergies and reactions.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

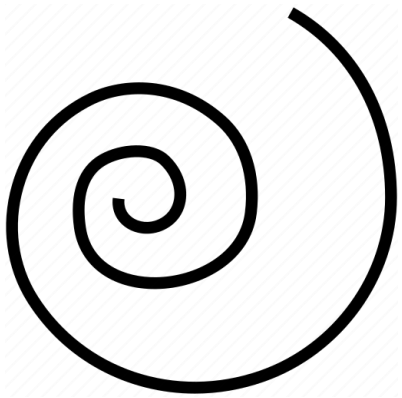
Family history

Has any blood relative had any of the following?____Unknown____Adopted

Relationship

__Alcoholism _____
__Aneurysm _____
__Cancer _____
__Depression _____
__Dementia _____
__Diabetes _____
__Early Death _____
__Heart disease _____
__High blood pressure_____
__Kidney disorder _____
__Mental illness _____
__Multiple Sclerosis _____
__Migraines _____
__Parkinson's _____
__Seizure(s) _____
__Stroke _____
__Substance abuse _____
__Suicide _____
__Thyroid disorder _____
__Other (please explain) _____
_____
_____

Please draw a line starting from the center and spiral out.



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