

# QUALITY NEUROLOGY

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

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

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

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

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

**May we leave a message on your voicemail?**  Yes  No

**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  Hispanic  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?** \_\_\_\_\_

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

**Patient Name:**



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><b>Have you had surgery on any of the following areas?</b></p>	<p><b>Has any blood relative had any of the following? <u>Unknown</u> <u>Adopted</u></b></p>
<p><input type="checkbox"/> Cancer  <input type="checkbox"/> Depression  <input type="checkbox"/> Diabetes  <input type="checkbox"/> High Blood Pressure  <input type="checkbox"/> Heart Condition  <input type="checkbox"/> Obesity  <input type="checkbox"/> Seizure  <input type="checkbox"/> Stroke</p>	<p style="text-align: right;">Year and Reason</p> <p><input type="checkbox"/> Brain _____  <input type="checkbox"/> Back _____  <input type="checkbox"/> Breast _____  <input type="checkbox"/> Cataract _____  <input type="checkbox"/> Gastric bypass _____  <input type="checkbox"/> Spine _____  <input type="checkbox"/> Other (please explain) _____  _____  _____  _____</p>	<p style="text-align: right;">Relationship</p> <p><input type="checkbox"/> Alcoholism _____  <input type="checkbox"/> Alzheimer's _____  <input type="checkbox"/> Aneurysm _____  <input type="checkbox"/> Cancer _____  <input type="checkbox"/> Depression _____  <input type="checkbox"/> Dementia _____  <input type="checkbox"/> Diabetes _____  <input type="checkbox"/> Early Death _____  <input type="checkbox"/> Heart disease _____  <input type="checkbox"/> High blood pressure _____  <input type="checkbox"/> Kidney disorder _____  <input type="checkbox"/> Leukemia _____  <input type="checkbox"/> Lupus _____  <input type="checkbox"/> Mental illness _____  <input type="checkbox"/> Multiple Sclerosis _____  <input type="checkbox"/> Migraines _____  <input type="checkbox"/> Parkinson's _____  <input type="checkbox"/> Rheumatoid arthritis _____  <input type="checkbox"/> Seizure(s) _____  <input type="checkbox"/> Stroke _____  <input type="checkbox"/> Substance abuse _____  <input type="checkbox"/> Suicide _____  <input type="checkbox"/> Thyroid disorder _____  <input type="checkbox"/> Other (please explain) _____  _____  _____</p>
<p style="text-align: center;"><b>Misc</b></p> <p>Who do you live with?  _____</p>	<p><b>Social history</b></p>	<p style="text-align: center;"><b>Have you received the COVID-19 Vaccine?</b></p> <p><input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Did you receive a booster?  <input type="checkbox"/> yes <input type="checkbox"/> no</p>
<p>What is/was your occupation?  _____</p> <p>Are you retired? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Handedness: (circle)  Right  Left  Ambidextrous</p> <p>Do you have a living will?  <input type="checkbox"/> yes <input type="checkbox"/> no</p>	<p>Alcohol use? <input type="checkbox"/> yes <input type="checkbox"/> no  Tobacco use? <input type="checkbox"/> current <input type="checkbox"/> former  # of years used _____</p>	<p><b>Please list any medication allergies and reactions.</b></p>
<p><b>Hospitalization</b></p>	<p><b>Please list any medication allergies and reactions.</b></p>	
<p>Have you ever been hospitalized?  _____  _____  _____  _____  _____  _____</p>	<p>_____  _____  _____  _____  _____  _____  _____  _____  _____</p>	

**Additional Information:**

**Patient Name:**

## 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

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