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:

_____

_____

_____

For what problem were you referred today? _____

Preferred Pharmacy: _____

Preferred Lab: _____

Preferred Imaging Facility: ____ Invision ____ Titan ____ Other: _____

Patient Name:

LIST CURRENT MEDICATIONS:

Drug Name	Dose	Frequency

Do you have any allergies? Please list allergy and reaction:

Allergy	Reaction

Patient Name:

REVIEW OF SYSTEMS:

CIRCLE ALL THAT APPLY

Fatigue
Vision Changes
Loss of Smell
Sinus Problems
Difficulty Hearing
Dizziness
Rashes
Chest Pain
Palpitations
Cough
Constipation
Reflux/GERD
Incontinence
ED
Falls

Muscle Aches
Joint Pain
Neck Pain
Thyroid Problems
Diabetes
Weakness
Headaches/Migraines
Seizures
Tremor
Memory Loss
Depression
Anxiety
Poor Sleep/Restless Sleep

Patient Name:

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

Surgeries/Operations

Have you had surgery on any of the following areas?

	Year of surgery
__Brain	_____
__Back	_____
__Breast	_____
__Cataract	_____
__Gastric bypass	_____
__Spine	_____

__Other (please explain) _____

_____

_____

Social history

Alcohol use? __ yes __no
# of drinks per day _____
Tobacco use? __ current __ former
# of years used _____
Type (circle): cigarettes, cigars/pipe, snuff/chewing tobacco, vape/eCigarette

Illegal drug use? __ yes __no

Family history

Has any blood relative had any of the following?____Unknown____Adopted

	Relationship
__Alcoholism	_____
__Alzheimer's	_____
__Aneurysm	_____
__Cancer	_____
__Depression	_____
__Dementia	_____
__Diabetes	_____
__Early Death	_____
__Heart disease	_____
__High blood pressure	_____
__Kidney disorder	_____
__Leukemia	_____
__Lupus	_____
__Mental illness	_____
__Multiple Sclerosis	_____
__Migraines	_____
__Parkinson's	_____
__Rheumatoid arthritis	_____
__Seizure(s)	_____
__Stroke	_____
__Substance abuse	_____
__Suicide	_____
__Thyroid disorder	_____

__Other (please explain) _____

_____

_____

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)

	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

Patient Name: