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
Rashes
Chest Pain
Palpitations
Cough
Constipation
Reflex/GERD
Incontinence
ED
Falls

Muscle Aches
Muscle Weakness
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	Surgeries/Operations	Family 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	**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	**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: