# 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**:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

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**For what problem were you referred today?** _______________________________________________

**Preferred Pharmacy:** ______________________________________________________________________

**Preferred Lab:** __________________________________________________________________________

**Preferred Imaging Facility:** ____ Invision ____ Titan ____ Other: _____________________________

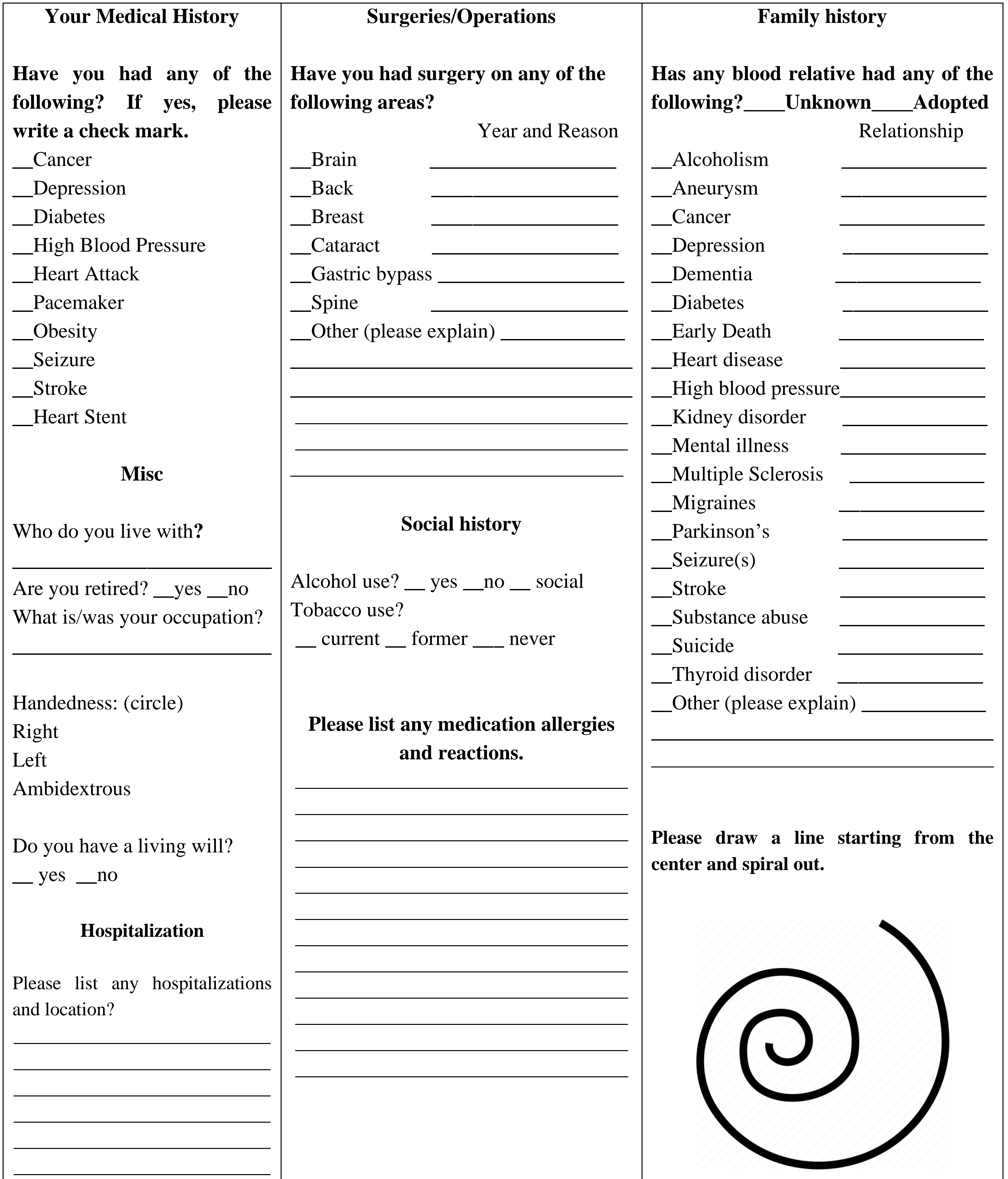
## LIST CURRENT MEDICATIONS:

| 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 Attack
__Pacemaker
__Obesity
__Seizure
__Stroke
__Heart Stent

**Misc**

Who do you live with**?**

____________________________

Are you retired? __yes __no
What is/was your occupation?

____________________________

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 |