

# NEUROLOGICAL SPECIALISTS, P.C.

Diseases of the Nervous System \* Sleep Disorders  
Electromyography \* Evoked Potentials  
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NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ FAMILY MD \_\_\_\_\_

### Previous Medical Illnesses:

Have you ever had the following?:

- Asthma
- Emphysema
- Hypertension
- Diabetes
- Heart Attack
- Anemia
- Ulcer Disease
- Seizure
- Stroke
- Thyroid Condition
- Alzheimer's Disease
- Parkinson's Disease
- Other \_\_\_\_\_
- None of the above

Left or Right Handed \_\_\_\_\_  
Sex: \_\_\_\_\_  
Race: \_\_\_\_\_  
Height: \_\_\_\_\_  
Weight: \_\_\_\_\_  
Age: \_\_\_\_\_  
Language \_\_\_\_\_

### Answer the following Yes or No

- \_\_\_\_\_ Do you snore?
- \_\_\_\_\_ Do you have high blood pressure
- \_\_\_\_\_ Has anyone told you that you stop breathing during sleep?
- \_\_\_\_\_ Do you feel tired or fatigued after you sleep?
- \_\_\_\_\_ Are you overweight?

### ALLERGIES:

Allergies to medications ( ) Yes ( ) No

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### PRESENT MEDICATIONS

List name, strength & how many times a day taking.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Present problems: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### FAMILY HISTORY: Please list known problems

Mother \_\_\_\_\_

Father \_\_\_\_\_

Siblings: \_\_\_\_\_

Mat GM \_\_\_\_\_

Mat GF \_\_\_\_\_

Pat GM \_\_\_\_\_

Pat GF \_\_\_\_\_