Neurology Associates of Arlington, P.A. - New Patient History

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Name_____ **Date**_____

Who referred you to us?_____

Who is your primary care doctor?_____

What is your main problem for seeing the neurologist? _____

_____

Which doctors have evaluated or treated you for this problem? _____

_____

Which other doctors have treated you the past 5 years? _____

_____

_____

Circle the medical problems that you have or that you had in the past

Neurological
Headaches
Stroke
Transient ischemic attack
Brain aneurysm
Brain tumor
Seizures
Parkinson s disease
Dementia
Meningitis
Encephalitis
Polio
Guillain-Barré syndrome
Peripheral neuropathy
Head injury
Spinal fracture
Sleep apnea
Restless legs syndrome

Eye
Macular degeneration
Glaucoma
Amblyopia (lazy eye)

Cardiovascular
High blood pressure
High cholesterol
Heart attack
Atrial fibrillation
Congestive heart failure

Respiratory
Asthma
Emphysema or COPD
Tuberculosis
Pulmonary embolism

Gastrointestinal
GE reflux
Peptic ulcer
Gallstones
Hepatitis
Vitamin B12 deficiency

Genitourinary
Kidney stones
Kidney failure or impairment
Erectile dysfunction
Menopause

Musculoskeletal & rheumatic
Lupus
Sjogren s syndrome
Scoliosis

Psychiatric
Depression
Anxiety
Phobias
Bipolar illness

Endocrine
Diabetes
Hypothyroid (low thyroid)
Hyperthyroid (overactive thyroid)

Allergy and Immunology
HIV or AIDS

Cancer
Lung cancer
Colon cancer
Prostate cancer
Breast cancer

Are you: right-handed left-handed ambidextrous (about the same)

Name _____

Circle the operations that you have had

Appendectomy	Pacemaker	Knee surgery	LASIK
Gallbladder	Defibrillator - ICD	Hysterectomy	Cataract □ right eye
Gastric band	Heart valve surgery	Right ovary removed	Cataract □ left eye
Gastric sleeve	Brain tumor	Left ovary removed	Retinal surgery □ right
Gastric bypass	Brain aneurysm	Tubal ligation	Retinal surgery □ left
Groin hernia	Neck surgery-spine	Uterine ablation	Nasal surgery
Right carotid	Low back surgery	Right kidney	Sinus surgery
Left carotid	Right carpal tunnel	Left kidney	Uvulopalatopharyngoplasty
Coronary bypass	Left carpal tunnel	Vasectomy	Tonsils & adenoids
Coronary angioplasty & stent	Joint replacement	Bladder surgery	Melanoma

Other operations_____

_____

Female Patients – indicate the number of each of the following

Pregnancies _____ Births_____ Miscarriages_____ Abortions_____

Date of last menstrual period_____ Type of birth control_____

Circle the types of medical equipment that you use.

Wheelchair	Power wheelchair	Power scooter	Cane	Walker
Elevated toilet	Tub bench	Hoyer lift	CPAP	BiPAP

Other equipment_____

Circle the medical problems of your blood relatives

Father	**Mother**	**Brother(s)**	**Sister(s)**
Dementia	Dementia	Dementia	Dementia
Diabetes	Diabetes	Diabetes	Diabetes
Headaches	Headaches	Headaches	Headaches
Heart attack	Heart attack	Heart attack	Heart attack
Multiple sclerosis	Multiple sclerosis	Multiple sclerosis	Multiple sclerosis
Muscular dystrophy	Muscular dystrophy	Muscular dystrophy	Muscular dystrophy
Narcolepsy	Narcolepsy	Narcolepsy	Narcolepsy
Parkinson□s disease	Parkinson□s disease	Parkinson□s disease	Parkinson□s disease
Peripheral neuropathy	Peripheral neuropathy	Peripheral neuropathy	Peripheral neuropathy
Restless legs	Restless legs	Restless legs	Restless legs
Seizures	Seizures	Seizures	Seizures
Sleep apnea	Sleep apnea	Sleep apnea	Sleep apnea
Stroke	Stroke	Stroke	Stroke
Tremor	Tremor	Tremor	Tremor

Other comments on your family medical history

Name _____

Do you smoke? Yes, daily Yes, not every day Never Used to smoke

Do you drink alcoholic beverages? Yes No

Circle if you have: living will medical power of attorney court appointed guardian

Marital status: single married divorced widowed separated

What is your work status? Please circle one.

Employed Unemployed On disability Homemaker Retired

Type of work:_____

What is your highest level of education?_____

Do you drive? Yes No I have been told not to drive

Type of housing House Condominium Apartment Mobile Home

Assisted Living Nursing Home

Circle the symptoms that you currently have.

General
Excessive fatigue

Eyes
Vision problems
Double vision

Ear, Nose, and Throat
Hearing loss
Dizziness

Cardiovascular
Palpitation or heart racing
Leg swelling

Respiratory
Cough
Wheezing
Shortness of breath

Gastrointestinal
Difficulty swallowing
Heartburn
Diarrhea
Constipation
Nausea

Genitourinary
Recent kidney stone
Bladder control problems
Erectile dysfunction

Musculoskeletal
Neck pain
Low back pain
Arm pain
Leg pain

Skin
Rash
Itching

Neurological
Headaches
Memory loss
Weakness
Numbness
Loss of coordination
Loss of balance
Daytime sleepiness
Disturbed sleep
Restless legs
Tremor
Burning pain in feet

Psychiatric
Depression
Anxiety
Excessive stress

Endocrine
Excessive thirst
Irregular menstrual periods

Hematology & Oncology
Easy bruising

Allergy and Immunology
Constant nasal discharge

Name _____

Write down drugs, tapes, or foods that you are allergic to or that you cannot tolerate and indicate the type of reaction that you have to it.

_____

_____

_____

_____

_____

Write down all medications, including non-prescription drugs and vitamins (or provide list).

Name	**Strength**	**How many times per day**

_____

_____

_____

_____

_____

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