NEUROLOGICAL MEDICINE, P.A.

PATIENT DATA BASE

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Handedness: ☐ Right ☐ Left

Referring Physician: _____ Height: _____ Weight: _____

Family Doctor: _____

Please state in a few sentences the problem for which your physician referred you to our neurology office:

_____

_____

List any tests done for this problem, where they were done, what they showed:

_____

_____

Have you lost time from work due to this problem? _____ When: _____

PAST MEDICAL HISTORY

Check if you had any of the following and indicate when:

	When		When
☐ Diabetes	_____	☐ Cancer	_____
☐ High blood pressure	_____	☐ Emphysema	_____
☐ Heart attack	_____	☐ Asthma	_____
☐ Stroke	_____	☐ Psychiatric disturbance	_____
☐ Epilepsy	_____	☐ Depression	_____
☐ Heart failure	_____	☐ Arthritis	_____
☐ Ulcer	_____	☐ Lupus	_____
☐ Glaucoma	_____	☐ Prostate problems	_____

SURGERY: (List all surgical operations)

Operation	Date	Physician	Hospital

HOSPITALIZATIONS: (List any problem requiring hospitalization – start with the most recent)

Problem	Date	Physician	Hospital

PHYSICIANS: (List other physicians you have consulted in the past 5 years)

Problem	Date	Physician

INJURIES: (List and serious injuries, particularly to your head, neck or back)

_____

_____

MEDICATIONS: (List all current medications)

Medication	Dosage	Date started

List any previous medications:

Medication	Reaction

ALLERGIES: (List medications and describe reaction)

Medication	Reaction

Other allergies? _____ Do you have asthma: ☐ Yes ☐ No

FOR FEMALE PATIENTS ONLY:

Birth control method: _____ Period regular? ☐ Yes ☐ No

Last menstrual period: _____ Date of last pelvic exam: _____

Number of pregnancies: _____ Number of miscarriages: _____ Name of Gynecologist: _____

FOR MALE PATIENTS ONLY:

Impotence? ☐ Yes ☐ No Loss of sexual abilities? ☐ Yes ☐ No

SOCIAL HISTORY

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

Employment/Occupation: _____ For how long? _____

If not working, when did you stop? _____ Previous Occupation: _____

How much do you smoke now? _____ Previously: _____

How often do you drink alcoholic beverages? _____

How much do you usually drink? _____

Education completed: _____

Have you had extensive exposure to chemicals or toxins?

☐ Radiation ☐ Asbestos ☐ Coarse dusts ☐ Loud noises

FAMILY HISTORY

Relative	Age/Ages if living	Present Health	Major illnesses State if past or present	If deceased, give age at death and cause
Father:				
Mother:				
Brothers:				
# living				
# deceased				
Sisters:				
# living				
# deceased				
Spouse:				
Children:				
# living				
# deceased				

Check any of the following problems which occurred in a member of your family:

- ☐ Diabetes
- ☐ Headaches
- ☐ Epilepsy, seizures or convulsions
- ☐ Mental retardation
- ☐ Nervous breakdown
- ☐ Serious alcohol problem
- ☐ High blood pressure
- ☐ Stroke
- ☐ Uncontrolled shaking or movements
- ☐ Early memory loss
- ☐ Psychiatric hospitalization
- ☐ Arthritis
- ☐ Heart attack
- ☐ Poor coordination
- ☐ Progressive weakness
- ☐ Progressive numbness
- ☐ Cancer
- ☐ Severe depression

REVIEW OF SYSTEMS

Have you had (check any that apply):

GENERAL

- ☐ Decreased appetite
- ☐ Increased appetite
- ☐ Recent weight gain (# lbs.)
- ☐ Recent weight loss (# lbs.)
- ☐ Fever
- ☐ Night sweats

EYES

- ☐ Double vision
- ☐ Change in vision

HEART AND CIRCULATION

- ☐ Chest pains
- ☐ Palpitations
- ☐ Rheumatic fever
- ☐ Require two pillows to sleep
- ☐ Late afternoon ankle swelling
- ☐ Heart attack
- ☐ Pacemaker

URINARY

- ☐ Urinary frequency
- ☐ Bladder infections
- ☐ Regular awakening to pass urine
- ☐ Burning when urinating
- ☐ Loss of control of urine
- ☐ Long pause before urine starts
- ☐ Feeling of not being able to completely empty bladder

EARS, NOSE, MOUTH, THROAT

- ☐ Sore throat
- ☐ Runny nose
- ☐ Nasal polyps
- ☐ Swollen glands
- ☐ Ringing in ears
- ☐ Pain in ears
- ☐ Sensation of spinning or unsteadiness
- ☐ Change in smell
- ☐ Change in taste

BREATHING

- ☐ Shortness of breath
- ☐ Cough
- ☐ Coughing up blood
- ☐ Pneumonia
- ☐ Tuberculosis

REVIEW OF SYSTEMS, *CONT.*

Have you had (check any that apply):

SKIN AND BREASTS

- ☐ Herpes zoster (shingles)
- ☐ Rash
- ☐ Increased dryness of skin
- ☐ Change in mole
- ☐ Change in nails
- ☐ Breast lump or swelling
- ☐ Discharge from nipples

ALLERGIC

- ☐ Environmental allergens
- ☐ Asthma
- ☐ Drug reactions
- ☐ Food reactions

BONES AND JOINTS

- ☐ Joint pain
- ☐ Back pain
- ☐ Sore muscles
- ☐ Muscle spasm

STOMACH AND BOWELS

- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloody stools
- ☐ Change in bowel habits
- ☐ Jaundice
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Loss of control of bowels

ENDOCRINE

- ☐ Racing heart
- ☐ Irregular periods
- ☐ Frequent urination
- ☐ Milk from breasts
- ☐ Blood and Lymph
- ☐ Bruising
- ☐ Swollen glands
- ☐ Anemia

BRAIN AND NERVES

- ☐ Seizures, convulsions, epilepsy
- ☐ Headache with nausea and vomiting
- ☐ Muscle cramps
- ☐ Unsteadiness in walking
- ☐ Tremors
- ☐ Fainting spells
- ☐ Been knocked unconscious
- ☐ Headache in one spot
- ☐ Loss of muscle size
- ☐ Leg cramps when walking
- ☐ Change in speech
- ☐ Stroke
- ☐ Difficulty swallowing
- ☐ Feeling of impending faint
- ☐ Headache
- ☐ Weakness all over
- ☐ Weakness in one part of body
- ☐ Difficulty with coordination
- ☐ Change in handwriting
- ☐ Recent persistent hoarseness

Pain, where? _____

Pins, needles or tingling feeling, where? _____

Numbness (loss of feeling), where? _____

PSYCHIATRIC

- ☐ Trouble sleeping
- ☐ Feel depressed
- ☐ Take a drink to relax
- ☐ Tire easily
- ☐ Feel that others don't understand you
- ☐ Psychiatric problems
- ☐ Worry a lot
- ☐ Feel nervous or tense
- ☐ Psychiatric hospitalization

PHARMACY INFORMATION:

Patient's Name: _____

Account # (office use only): _____

Retail Pharmacy Name: _____

Address: _____

Phone Number: _____

Mail Order Pharmacy: _____

FOR OFFICE USE ONLY:

Physician Signature: _____ Date: _____

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THERE'S A FAST NEW WAY TO CONNECT WITH US!

Neurological Medicine, P.A. is pleased to provide our patients the *Allscripts Patient Portal*. Powered by Intuit Health, this is a self-service online tool that lets you connect with our practice where and when it fits your busy schedule.

Log onto *WWW.NEUROMEDPA.COM* (secure and confidential). Click "*Patient Portal*."

***** PLEASE NOTE *****

When creating your account, please use a DESKTOP or LAPTOP computer as this is a secured network.
Once you have successfully created an account, you will be able to log onto the patient portal from any device.

PORTAL FEATURES:

- » ***APPOINTMENT REQUESTS***
  - Submit requests whenever you want, wherever you are, even when the office is closed.
- » ***PRESCRIPTION RENEWALS***
  - Submit requests at home, on the road, or whenever you need.
- » ***PRE-REGISTRATION FORMS***
  - Fill out forms at home and spend less time in the waiting room.
- » ***SECURE MESSAGING***
  - Receive lab results, appointment reminders, office updates, and more.
- » ***SYMPTOM MANAGEMENT***
  - Get a head start. Submit symptoms prior to visit, reducing time in the office.
- » ***ASK A CLINICIAN***
  - Submit non-urgent questions to medical staff anytime.
- » ***PERSONAL HEALTH RECORDS***
  - The simple way to access and manage your medical records.

PATIENT NAME: _____

EMAIL ADDRESS: _____

D.O.B.: _____

ACCOUNT # (FOR OFFICE USE ONLY): _____

LAUREL MEDICAL ARTS PAVILION
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