

NEUROLOGICAL CONSULTANTS, P.C.



Name _____

Today's Date _____

Referred by _____ Age _____

Dr. _____

Please answer each of the following questions briefly; your doctor will review them with you.

Which symptom or problem would you like addressed today?

Where do you feel this problem in your body?

How long have you ever had these symptoms?

When these symptoms occur, how long do they last?

How often do these symptoms occur, on average?

What is the severity of these symptoms? (please circle)

Mild Moderate Severe Intolerable

What does this problem feel like? How would you describe it?

What makes this problem worse? What makes it better?

Are there other symptoms that occur along with this problem?

What over the counter medications have you tried for this problem?

What prescription medications have you tried for this problem?

Which medications, if any, have been helpful?

Have you had any medical tests to evaluate these symptoms? When?

Past Medical History

Stroke/"mini" stroke? _____

Headaches/migraines? _____

Seizure/Epilepsy? _____

Heart Disease? _____

High blood pressure? _____

Diabetes? _____

Other: _____

What is your current height? _____ and current weight? _____

Past Surgical History

Cataract removal? _____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____
_____	Year: _____

Social History

Education Level: GED High School Technical College Post-Graduate

Current Job Title _____

Alcohol Use: (please circle) Never Rarely Weekly Daily Amount: _____

Tobacco Use: (please circle) Never Quit (what year? _____) Currently Pack(s) per day: _____

Illicit Drug Use: (please circle) Never Occasionally Daily Substance: _____

Have you ever required a: cane walker brace wheelchair

Do you need help with bathing or dressing? Yes No Are you currently on disability? Yes No

Marital Status: (please circle) Single Married Partner Divorced Separated Widowed

Do you exercise regularly? What is your usual routine? _____

Who lives with you at home? _____

How many children do you have? ___ Sons ___ Daughters Any miscarriages? ___

How many siblings do you have? ___ Brothers ___ Sisters ___ Are you adopted? ___

