

Name:

ACCT#:

Noran Neurology Provider:

DOB:

Age:

Gender:

What symptoms or neurologic condition are you being seen for today?

List:

Do you have any other new medical conditions?

Yes No

Pregnant? Yes No

List:

Have you been to the ER or hospitalized recently?

Yes No

Recent Surgery? Yes No

Details:

Have you had any recent changes in your job or family? Yes No

Details:

Are there any recent changes in your family's health? Yes No

Details:

Review of symptoms (mark below all that apply):

Head

- headache
- loss of vision
- spinning dizziness
- light headedness

Other Neurologic

- difficulty concentrating
- memory loss
- trouble walking
- falling
- arm weakness
- leg weakness
- numbness / tingling
- shaking / tremor

Other

—

Musculoskeletal

- neck pain
- mid back pain
- low back pain
- shoulder pain
- knee pain
- other joint pain

Psychiatric

- depression
- anxiety

Cardiovascular

- palpitations
- swelling of feet

Respiratory

- shortness of breath

Gastrointestinal

- vomiting
- loss of bowel control

Genitourinary

- frequent urination
- loss of bladder control

Hematologic/Lymphatic

- bleeding tendency
- blood clots

Skin

- rash
- hair loss

General

- weight loss
- weight gain

Sleep

- snoring
- choking/gasping in sleep
- daytime sleepiness
- morning headaches
- waking feeling unrefreshed
- difficulty falling asleep
- aching/crawling sensation in legs
- neck size 17 inches or larger

Circle the number that relates to your overall level of pain **today**:

(none) 1 2 3 4 5 6 7 8 9 10 (worst)



Signature: _____ Date: _____

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Past Medical History: mark below all that apply to you

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Sleep apnea |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Deep vein thrombosis | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Anxiety Disorder | <input type="checkbox"/> Depression | <input type="checkbox"/> HIV / AIDS | <input type="checkbox"/> Systemic lupus |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Epilepsy / seizures | <input type="checkbox"/> Multiple sclerosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Neuropathy | |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Bipolar disorder | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Parkinson's Disease | |
| <input type="checkbox"/> Cancer / Tumor | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatoid arthritis | |

Past Surgeries: write below your past surgeries and approximate year none

Past Injuries: write below your injuries and approximate date none

Medications: list drugs and dosing (if known) below

Allergies: list drugs and reaction below

Social History:

Education: How many years of school have you completed? _____ Are you in school now? yes no

Are work hours restricted? yes no

Other restrictions? (List)

If not working: When did you last work? _____ When might you return to work? _____

Occupation(s): _____ Handedness: right left

Military history? none current previous

Marital status: single partnered married separated divorced widowed

Number of children: _____

Tobacco use: Never Smoked Previous smoker, if quit, year quit? _____ Current Smoker, how much? _____

How often? _____ Unknown if ever smoked

Alcohol use: yes no Amount and frequency? _____ If quit, when? _____

Caffeine use: yes no Amount and frequency? _____ If quit, when? _____

Family History: mark below if a close relative (mother, father, sister, brother, child) has had any of the following problems:

Problem	Relative	Problem	Relative
Attention deficit disorder		Mental illness	
Alzheimer's disease/dementia		Multiple sclerosis	
Birth defect		Muscle disease	
Brain tumor		Neuropathy	
Brain aneurysm		Parkinson's disease	
Difficulty walking		Stroke	
Epilepsy/seizures		Tics/Tourette's	
Headaches/migraines		Tremor	
Huntington's chorea		Other neurologic	
Intellectual disability			

Mother: living deceased

Father: living deceased

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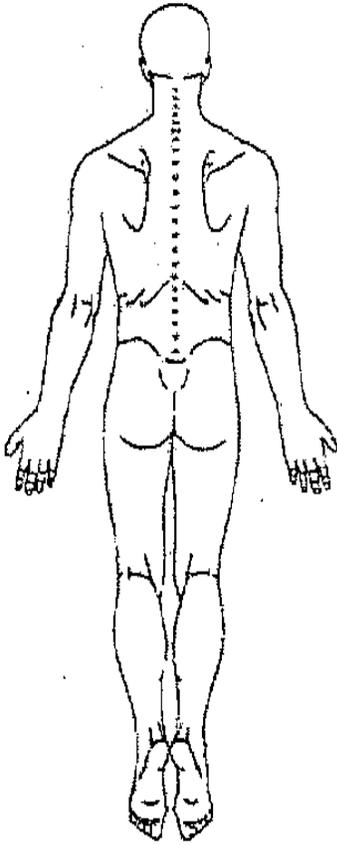
DOB:

Age:

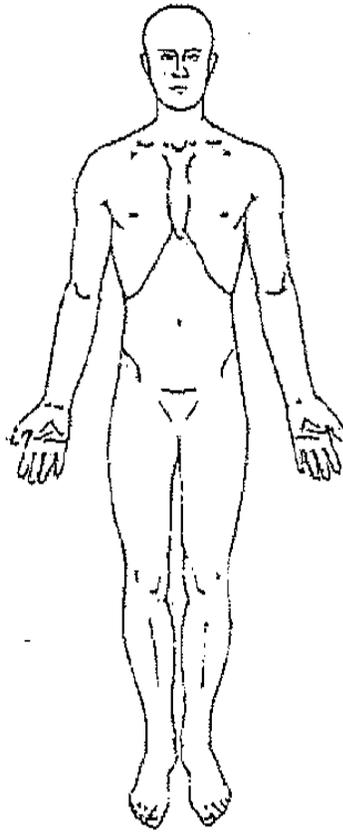
Gender:

If you are having pain or numbness:

Shade in areas of pain or numbness below:



Left Right



Right Left