

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 all that apply to you)

anemia		dementia		heart failure		sleep apnea	
angina		dementia-Alzheimer's		hepatitis		stroke/TIA	
anxiety disorder		dementia-vascular		high blood pressure		systemic lupus	
arthritis		depression		high cholesterol		thyroid disease	
arrhythmia		diabetes		HIV/AIDS		ulcers	
asthma		epilepsy/seizures		kidney problems			
atrial fibrillation		glaucoma		multiple sclerosis		other:	
bipolar disorder		headache		neuropathy			
cancer/tumor		headache-migraine		pacemaker			
chemical dependency		headache-tension		Parkinson's disease			
deep vein thrombosis		heart attack		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:

Name:

ACCT#:

Noran Neurology Provider:

DOB:

Age:

Gender:

Problem

Relative

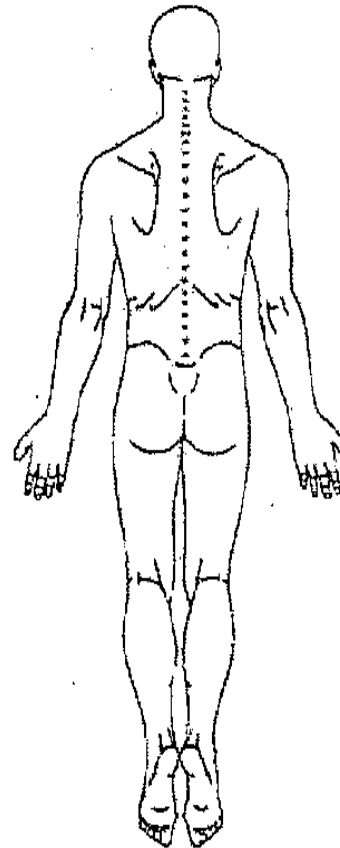
attention deficit disorder	
brain tumor	
brain aneurysm	
dementia	
dementia-Alzheimer's	
dementia - vascular	
epilepsy/seizures	
headache	
headache - migraine	
headache - tension	
multiple sclerosis	
muscle disease	
neuropathy	
Parkinson's disease	
stroke	
tics/Tourette's	
tremor	
other neurologic	

Mother:  living  deceased

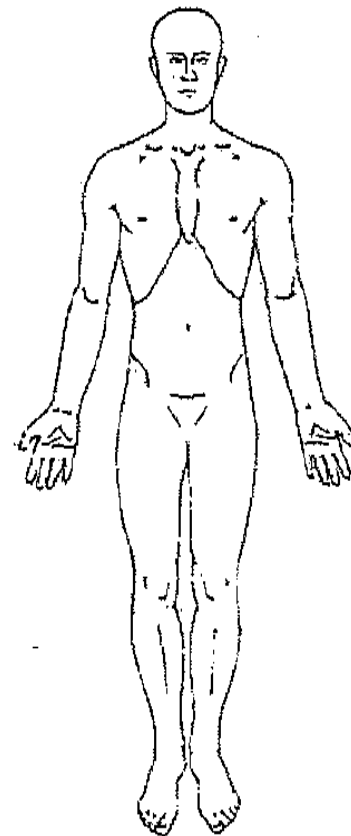
Father:  living  deceased

If you are having pain or numbness:

Shade in areas of pain or numbness below:



Left Right



Right Left

