NEW PATIENT BACKGROUND INFORMATION — NEUROLOGICAL SPECIALISTS, P.C.

NAME: ______________________ TODAY'S DATE: ______________

REFERRING PHYSICIAN ______________________ PRIMARY PHYSICIAN ______________
(IF DIFFERENT)

DATE OF BIRTH ____________ AGE ________ HEIGHT ________ WEIGHT ________

CHIEF COMPLAINT / MAIN PROBLEM: ______________________

SOCIAL HISTORY: **ARE YOU: (CHECK THOSE THAT APPLY)**

RIGHT HANDED _____ LEFT HANDED _____ AMBIDEXTROUS _____

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____

OCCUPATION: ______________________ RETIRED?: YES _____ NO _____

DO YOU SMOKE CIGARETTES? NO ______ YES ______ HOW MANY PER DAY? __________

DO YOU DRINK ALCOHOL? NO ______ YES ______ HOW MUCH? ______________

PAST MEDICAL HISTORY (CHECK THOSE WHICH APPLY)

_____	HIGH BLOOD PRESSURE	_____	DIABETES	_____	HIGH CHOLESTEROL
_____	HEART ATTACKS	_____	ARRYTHMIAS	_____	LUNG DISEASES
_____	THYROID PROBLEMS	_____	LIVER/HEPATITIS	_____	KIDNEY PROBLEMS
_____	CANCER	_____	ULCERS	_____	BLEEDING PROBLEMS
_____	ARTHRITIS	_____	HIV	_____	VENEREAL DISEASES
_____	DEPRESSION	_____	ANXIETY	_____	PSYCHIATRIC
_____	STROKES	_____	SEIZURES/EPILEPSY	_____	MIGRAINE/HEADACHES

SURGERY / OTHER ______________________

SURGERY / OTHER ______________________

OTHER ______________________

MEDICATIONS CURRENTLY USED: (INCLUDING NON-PRESCRIPTION MEDS, VITAMINS, ETC.)

______________ ______________ ______________

______________ ______________ ______________

______________ ______________ ______________

MEDICATION ALLERGIES

____

FAMILY HISTORY. LIST ANY NEUROLOGICAL OR MEDICAL PROBLEMS THAT RUN IN THE FAMILY:

MOTHER ______________ CHILDREN ______________

FATHER ______________ ______________

SISTER(S) ______________ ______________

BROTHER(S) ______________ ______________

OTHER RELATIVES WITH SIGNIFICANT ILLNESSES: ______________

LIST ANY TESTING DONE FOR CURRENT PROBLEM

	TEST	WHERE	WHEN
BLOOD TESTS			
EEG			
CT / MRI			
ECHO/DOPPLERS			
OTHER TESTS?			

RECORDED BY ______________________