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NEUROLOGY PATIENT HISTORY

Date:_____

Name:_____

Age: _____

Name of primary care physician who should receive the report of this consultation:
_____

Chief Complaint(s): List the main problem(s) for which you are seeking a Neurology Consultation (e.g. headache, pain, weakness, etc.)

Problem Duration

_____

_____

_____

_____

_____

Describe your main problem in detail:
Date of onset (approximate time):

Duration:

Progression:

Location (e.g. right leg, front of head, etc.):

Severity:

Continue…

Neurology Patient History : Describe your main problem in detail

Frequency:

Other associated symptoms:

Aggravating factors:

Comments:

Neurology Questionnaire
Check (√) Which symptoms or diseases you have had.

Symptom	(√)	Onset
Headache (temporary)		
Blindness(Permanent)		
Facial Pain		
Asymmetry of face		
Ear pain		
Ear discharge		
Ringing in the ears		
Deafness		
Difficulty swallowing		
Difficulty sucking		
Difficulty chewing		
Difficulty talking		
Difficulty breathing		
Chest pain/pressure		
Palpitations		
Nausea		
Vomiting		
Abdominal pain		
Neck pain		
Back pain		
Tingling		
Numbness		
Burning feet		
Weakness of arms		
Weakness of legs		
Fatigue		
Weight Loss		

CONTINUE…

NEUROLOGY QUESTIONNAIRE

Check (√) Which symptoms or disease have you had

Symptom/Disease	(√)	Onset
Thinning of muscles		
Abnormal gait		
Stiffness		
Tremor/Abnormal Movements		
Memory Loss		
Confusion		
Loss of Consciousness		
"Blackout" spells		
Seizures(Epilepsy)		
Syncope		
Stroke(Paralysis)		
TIA or warning strokes		
Urinary problems		
Difficulty of bowl movement		
Sexual Dysfunction		
Skin rashes		
Joint pains/swelling		
Sleep disturbances		
Recurrent fever		
High Blood Pressure		
Diabetes		
Heart disease		
Kidney disease		
Cancer		
Surgery for:		

1) Social History:
Married/Single/Divorced (Circle One)

Occupation: _____

Alcohol: _____

Smoking: _____

Recreational Drugs: _____

NEUROLOGY QUESTIONNAIRE

2) FAMILY HISTORY:

	YES/NO	RELATIONSHIP
Hypertension		
Diabetes		
Kidney Disease		
Tuberculosis		
Muscular Dystrophy		
Seizure Disorder		
Headaches/Migraine		

3) LIST ALL MEDICATIONS: (Include birth control pills, Aspirin, and over the counter medications.

NAME OF DRUG	DOSAGE	HOW OFTEN	DATE STARTED

4) ALLERGIES, IF ANY: _____

_____

5) HAVE YOU HAD A PRIOR NEUROLOGICAL EVALUTAION, CAT SCAN, MRI EXAM, EEG, OR EMG? IF SO, GIVE THE REASON FOR THE EXAM IF KNOWN AND THE NAME OF THE ORDERING PHYSICIAN:

_____

_____

6) IS THERE ANY OTHER PERTINENT INFORMATION YOU WOULD LIKE TO SHARE?

IF YOU HAVE ANY SPECIAL QUESTIONS OR CONCERNS PLEASE USE THIS SPACE.

Thank you for taking the time to fill out this history form. This will help me get to know you better and hopefully aid in your diagnosis and therapy.