UB|MD NEUROLOGY

UBMD NEUROLOGY – INITIAL VISIT

Patient:_____ D.O.B:_____ Date:_____

History obtained from (please check one):

☐Patient /☐Relative /☐Caretaker

Referring Doctor:_____

Main Complaint:_____

When did it start:_____

Allergies:_____

For Office Use Only

Vital Signs: B/P (R-sitting): _____ RR: _____

HR/Rhythm_____ WT: _____

Past Medical History (Mark the appropriate boxes with an X)

Medical Problems	Patient	Mom	Dad	Sister	Brother	Daughter	Son	Grandparent	Aunt/Uncle
Cancer									
Cardiac Disease									
Diabetes									
Epilepsy									
Headaches									
Hypertension									
Mental Illness									
Multiple Sclerosis									
Neck/Back Pain									
Parkinson's Disease									
Stroke									
Thyroid Disease									

Other Illnesses:_____

_____

Medications & Dosage:_____

_____

Past Surgeries:_____

Social History: Lives alone / with Spouse / Children / Other

Alcohol: □ Yes / □ No – □ Socially / □ Occasionally / □ Frequently

Amount per week:_____ Date Stopped:_____

Smoking: □ Yes / □ No – □ Socially / □ Occasionally / □ Frequently

Amount per week:_____ Date Stopped:_____

Drugs: □ Yes / □ No

Type: _____

Employment History: _____

_____

Highest Level of Education Completed: _____

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REVIEW OF SYSTEMS

Name:_____ D.O.B.: _____ Date:_____

Select any symptoms that you have had recently

Constitutional:

□ Fever □ Excessive Fatigue □ Recent Weight Gain - How much? _____

□ Chills □ Night Sweats □ Recent Weight Loss - How much? _____

Eyes:

□ Dry Eyes □ Eyesight Problems □ Red Eyes □ Loss of Vision

Ear/Nose/Throat:

□ Loss of Hearing □ Snoring □ Change in Voice

□ Nose bleeds □ Sinusitis □ Ringing in the ear

Respiratory:

□ Wheezing □ Shortness of Breath □Cough □ Phlegm/Sputum Production

Cardiovascular:

□ Chest Pain □ Palpitations □ Lower Extremity Edema

□ Leg Pain/Cramping □Fainting

Gastrointestinal:

□ Change in Appetite □ Heartburn □ Difficulty Swallowing □ Nausea □ Vomiting □ Abdominal Pain

□ Bloody/Black Stools □ Diarrhea □ Constipation

Genitourinary:

□ Urination at Night □ Frequent Urination □ Incomplete Emptying of Bladder

□ Blood in Urine □ Burning during Urination □ Unable to Restrain Urine

□ Sexual Problems

Musculoskeletal:

□ Persistent/Severe Back Pain □ Persistent/Severe Neck Pain

□ Muscle Pain or Cramps □ Persistent/Severe Joint Pain

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Review of Systems Continued

Name:_____ Date:_____

Skin:

□ Skin Rash □ Skin Growth □ Itching □ Change in Mole

Neurological:

□ Headaches □ Tremor □ Muscle Weakness □ Involuntary Movements

□ Numbness □ Falls □ Dizziness □ Memory Lapses/Losses

Psychosocial:

□ Anxiety □ Depression □ Panic Attacks □ Memory Lapses/Losses

Endocrine:

□ Temperature Intolerance □ Hot Flashes □ Excessive Thirst

Heme/Lymphatics:

□ Easy Bruising □ Easy Bleeding □ Swollen Lymph Nodes

Allergy/Immune:

□ Severe Allergic Reaction □ Hives □ Frequent Infections

Other pertinent information: _____

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MEDICATION LIST
****PLEASE OBTAIN A PRINTOUT FROM YOUR PHARMACY IF POSSIBLE! ****

PATIENT NAME:_____ DATE OF BIRTH: _____

ALLERGIES: _____

Medication / Dosage / Frequency	Dates of Service / Date of Last Refill				
Initial if medication list reviewed:					
Comment:					

PHARMACY: _____ PHARMACY TELEPHONE: _____