

UBMD NEUROLOGY – INITIAL VISIT

Patient: _____
 History obtained from (please check one):
 Patient / Relative / Caretaker
 Referring Doctor: _____
 Main Complaint: _____
 When did it start: _____
 Allergies: _____

D.O.B: _____ Date: _____

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: _____

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

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: _____

