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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BARTHEL INDEX / MODIFIED RANKIN

Patient Name:_____ Date:_____

PLEASE MARK THE RESPONSE WHICH BEST REFLECTS YOUR CURRENT STATUS FOR THE FOLLOWING ACTIVITY:

FEEDING:

- ☐ Unable (0)
- ☐ Needs help cutting, spreading butter, etc., or requires modified diet (5)
- ☐ Independent (10)

BATHING:

- ☐ Dependent (0)
- ☐ Independent (or in shower) (5)

GROOMING:

- ☐ Needs help with personal care (0)
- ☐ Independent face/hair/teeth/shaving (implements provided) (5)

DRESSING:

- ☐ Dependent (0)
- ☐ Needs help but can do about half unaided (5)
- ☐ Independent (including buttons, zips, laces, etc.) (10)

BOWELS:

- ☐ Incontinent, (or needs to be given enemas) (0)
- ☐ Occasional Accident (5)
- ☐ Continent (10)

BLADDER:

- ☐ Incontinent, or catheterized and unable to manage alone (0)
- ☐ Occasional Accident (5)
- ☐ Continent (10)

TOLIET USE:

- ☐ Dependent (0)
- ☐ Needs some help, but can do somethings alone (5)
- ☐ Independent (on and off, dressing wiping) (10)

TRANSFERS (BED TO CHAIR AND BACK):

- ☐ Unable, no sitting balance (0)
- ☐ Major help (one or two people, physical), can sit (5)
- ☐ Minor help (verbal or physical) (10)
- ☐ Independent (15)

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MOBILITY (ON LEVEL SURFACE):

- ☐ Immobile or <50 yards (0)
- ☐ Wheelchair Independent, including corners >50 yards (5)
- ☐ Walks with help of one person (verbal or physical) >50 yards (10)
- ☐ Independent (but may use any aid, for example stick) >50 yards (15)

STAIRS:

- ☐ Unable (0)
- ☐ Needs help (verbal, physical, carrying aid) (5)
- ☐ Independent (10)

THE PATIENT HEALTH QUESTIONNAIRE -2 (PHQ-2)
Select the correct response for each question

Over the past 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things
   □ Not at all □ Several days □ More than half the days □ Nearly every day

2. Feeling down, depressed or hopeless
   □ Not at all □ Several days □ More than half the days □ Nearly every day

Patient Initials/Date: _____

(TO BE COMPLETED BY PROVIDER)
MODIFIED RANKIN SCALE

0. No symptoms at all
1. No significant disability despite symptoms; able to carry out all usual duties and activities
2. Slight disability; unable to carry out all previous activities, but able to look after own affairs without assistance
3. Moderate disability; requiring some help, but able to walk without assistance
4. Moderately sever disability; unable to walk without assistance and unable to attend to own bodily needs without assistance
5. Severe disability; bedridden, incontinent and requiring constant nursing care and attention
6. Dead

TOTAL (0-6) _____

Provider Signature/Date: _____

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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: _____

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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: _____