



FOUR PEAKS NEUROLOGY

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Neurological Health History – Initial Consult

Name: _____ Who referred you to us? _____
Birthdate: _____ Primary Care Physician: _____
Age: _____ Other Physicians Involved in Care: _____
Race: _____

Right handed: _____ Left handed: _____

For what reason are you seeing us today?

When did your symptoms first start? _____
Location of symptoms? _____
Severity of symptoms. (Scale of 1-10) _____
Worse at any certain time of day? _____
What makes it better? _____
What makes it worse? _____
Does this problem affect your job? _____ Social life? _____ Family life? _____ Exercise? _____

Allergies to Medications: _____

Over-the-Counter Medications: _____

PAST MEDICAL HISTORY: (Circle)

- | | | | |
|---------------------------|------------------|---------------------|-----------------|
| Seizures | Angina | Heart Attack | Arrhythmia |
| Stroke | Asthma | Stomach Ulcers | Hepatitis |
| Spine Problems | Arthritis | Muscle Disease | Kidney Problems |
| Anxiety | Drug Abuse | Diabetes | Hypertension |
| Depression | Prostate Disease | Blood Clots | Kidney Stones |
| Panic Attack | Thyroid Disease | High Cholesterol | |
| Broken Bones: What? _____ | | Cancer: Type? _____ | |

SURGICAL HISTORY: _____

Patient Name: _____

DOB: _____

SOCIAL HISTORY:

Single _____ Married _____ Widowed _____ Partner _____

With whom do you live? _____

Employment/Occupation: _____

Tobacco use: Yes _____ No _____ Never _____

How many years? _____ How many packs per day? _____ When did you quit? _____

Alcohol use: Yes _____ No _____

Beer? _____ Wine? _____ Hard Liquor? _____ How many per day? _____ Qty per week? _____

Servings per day of: Coffee _____ Tea _____ Caffeinated Soda _____ Chocolate _____

FAMILY HISTORY:

_____ Similar type of illnesses that you have now

_____ Stroke

_____ Alzheimer's Dementia

_____ Seizures/Epilepsy

_____ Muscle Disease

_____ Nerve Disease/Neuropathy

_____ Tremor

_____ Brain Aneurysms

_____ Heart Disease

_____ High Blood Pressure

_____ Diabetes

_____ Cancer

_____ Blood Clotting Disorder

_____ Other

_____ Parkinson's Disease

SYSTEM REVIEW: (Please circle all that apply)

GENERAL: Fever, Chills or Sweats, Fatigue, Headaches.

EYES: Visual loss or double vision.

ENT: Hearing loss or ringing in ear. Difficulty speaking or difficulty swallowing.

CARDIOVASCULAR: Syncope (passing out). Chest pain, Cyanosis (blue discoloration to skin, clubbing or edema).

RESPIRATORY: Exertional shortness of breath. Shortness of breath. Wheezing or asthma symptoms.

GI: Nausea, vomiting, diarrhea, constipation.

URINARY: Painful urination, unusual urination at night, symptoms of infection.

MUSCULOSKELETAL: Acute swelling, myalgias, cramping.

ENDOCRINE: Intolerance to heat/cold, excessive thirst, excessive urination.

SKIN: Hives, Rash.

PSYCHIATRIC: Psychotic thoughts or hallucinations. Depression or anxiety. Sleep problems.

HEME/LYMPH: Abnormal bleeding or abnormal clotting.