

MEADOWBROOK NEUROLOGY GROUP

NAME: _____ Birthdate ____/____/____ Age _____

Reason for Neurological Evaluation: _____

Are You: Right-handed Left-handed Ambidextrous

MEDICATIONS: Please list current medications including prescription and non-prescription (over the counter) drugs, vitamins, supplements, etc. Include the milligram dosage and how often you take them.

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

- | | | |
|--|--|--|
| <input type="checkbox"/> TIA | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Atrial Fibrillation | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Heart Failure | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Heart Valve Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Fainting | Type _____ |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Brain Tumor | <input type="checkbox"/> Asthma | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Spinal Tumor | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Stomach Ulcers/GERD | <input type="checkbox"/> Psychosis |
| <input type="checkbox"/> Encephalitis | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Concussion | <input type="checkbox"/> Pregnancies/deliveries | <input type="checkbox"/> Drug Abuse |
| <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Syphilis | <input type="checkbox"/> AIDS/HIV |
| <input type="checkbox"/> Spine Injury | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Tuberculosis |
| | | <input type="checkbox"/> Sleep Apnea |

PLEASE LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

ALLERGIES: Please list all medications that have caused you to have an allergic reaction or other serious side-effect. List name of drug and brief description of reaction.

PLEASE LIST ANY SURGERY YOU HAVE HAD:

NAME: _____

Birthdate ____/____/____

Age _____

FAMILY HISTORY:

1. Do any blood relatives have a problem/diagnosis similar to your current problem?

Yes No

2. Have any of your blood relatives ever had any of the following?

Stroke Epilepsy Migraine Alzheimer's disease
 Parkinson's disease Multiple Sclerosis Neuropathy

3. List any other medical conditions that your parents, siblings or children have or have had:

SOCIAL HISTORY:

SMOKING:

Never smoked Quit Smoking: When did you quit? _____
 Currently smoking How much? _____

ALCOHOL USE:

Never Socially 1/day More than 2/day in recovery

RECREATIONAL DRUG USE:

Never Sometimes Frequent What type? _____
Have you ever injected drugs? Yes No

WORK STATUS:

Retired Disabled Work outside the home Occupation _____

MARITAL STATUS:

Single Married Divorced Living with significant other Widowed

DO YOU CURRENTLY DRIVE?

Yes No

DO YOU HAVE AN ACTIVE DRIVERS LICENSE?

Yes No

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?

High School College Graduate School

REVIEW OF SYSTEMS: Please check any of the following symptoms you have had recently:

- | | | |
|--|---|---|
| <input type="checkbox"/> Persistent Fever | <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Unexplained Weight Loss | <input type="checkbox"/> Rash | <input type="checkbox"/> Persistent Dizziness |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Difficulty Speaking |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Blood Clots in Legs or Lungs | <input type="checkbox"/> Difficulty Swallowing |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Weakness in Arms or Legs |
| <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Trouble Sleeping | <input type="checkbox"/> Numbness |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Headache | <input type="checkbox"/> Tingling |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Loss of Balance |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Difficulty Walking |
| <input type="checkbox"/> Discolored Urine | <input type="checkbox"/> Blindness | <input type="checkbox"/> Confusion |
| <input type="checkbox"/> Urinary Incontinence | <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Memory Loss |
| <input type="checkbox"/> Bowel Incontinence | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Impotence |
| <input type="checkbox"/> Muscle Pain | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Tremor |

DATE OF LAST MENSTRUAL PERIOD:
