North Shore Neurology New Patient Intake Form

All information in this form is confidential- ANSWER ALL 6 PAGES

Name:_____ Primary Care Doctor:_____

Date:_____ Referred by:_____

Age:_____ Birthday:_____ Height: _____ Weight: _____

Previous Neurologists Seen:_____ Chief Complaint:_____

Best Phone Number To Be Reached At:_____

Please Circle ALL THAT APPLY TO YOU

General:

- Fever
- Chills
- Sweats
- Night sweats
- Anorexia
- Fatigue
- Weight loss
- Weight gain

Eyes:

- Pain
- Redness
- Blurred vision
- Double vision
- Itchy eyes
- Watery eyes
- Discharge from eyes
- Loss of vision
- Light sensitivity

Ears/Nose/Throat:

- Ear pain
- Ear discharge
- Ringing in the ears
- Hearing loss
- Nasal congestion
- Nose bleeds
- Sore throat
- Hoarseness
- Swallowing trouble/pain

Cardiovascular:

- Chest pain
- Palpitations
- Shortness of breath with exercise
- Trouble breathing when lying down
- Trouble breathing at night
- Leg swelling
- Leg pain when walking distances
- Fainting spells/Lightheadedness

Respiratory:

- Cough
- Shortness of breath at rest
- Shortness of breath with exercise
- Excessive phlegm
- Coughing up blood
- Wheezing

Gastrointestinal:

- Loss of appetite
- Nausea
- Vomiting
- Diarrhea
- Constipation
- Change in bowel habits
- Abdominal pain
- Abdominal bloating
- Black stools
- Bloody stools
- Jaundice
- Heartburn
- Indigestion
- Hemorrhoids
- Weight Loss

Genitourinary:

- Painful urination
- Blood in urine
- Penile discharge
- Frequent urinations
- Urinary hesitancy
- Urinary urgency
- Frequent urinations at night
- Incontinence
- Decreased sex drive
- Erectile dysfunction
- Testicular mass or tenderness

Musculoskeletal:

- Joint pain
- Joint swelling
- Muscle cramps
- Muscle aches
- Muscle weakness
- Numbness in the pelvis

Skin:

- Rash
- Itching
- Dry skin
- Changing/Suspicious Spots
- Non-healing sores
- Bruising

Neurologic:

- Weakness
- Seizures
- Tremors
- Vertigo
- Frequent headaches
- Tingling
- Numbness
- Visual changes
- Incontinence
- Numbness in the pelvic region

Mental Health:

- Sleep problems
- Mood swings
- Depressed mood
- Confusion
- Suicidal thoughts
- Memory Loss
- Increased Irritability
- Anxiety/Panic Attacks
- Difficulty concentrating
- Hallucinations
- Excessive energy
- Decreased energy

Endocrine:

- Heat intolerance
- Cold intolerance
- Excessive thirst
- Excessive urination
- Weight loss
- Weight gain
- Constipation
- Diarrhea
- Hair loss
- Dry skin
- Tremor
- Excessive Tremor

Hematologic

- Bleeding
- Easy bruising
- Enlarged lymph nodes
- weight loss
- night sweats
- on anticoagulants

Allergic/Immunologic

Hay fever

Seasonal allergies

Hives

Frequent infections

Frequent sneezing

Itchy eyes

Eczema

Latex sensitivity

Hx of immune deficiency

Please list any other symptoms not mentioned:

_____
_____
_____
_____
_____

PAST MEDICAL HISTORY:

Please list all previous medical and surgical problems with dates:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES:

_____
_____
_____
_____
_____

PRESCRIPTION AND OVER THE COUNTER MEDICATION: LIST DOSE AND FREQUENCY

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:

Mother: Age: Deceased? Health Problems:

Father: Age: Deceased? Health Problems:

Siblings: Brothers, how many? Sisters, how many? Health Problems:

Pregnant: Yes No Last Menstrual Period_____

SOCIAL HISTORY:

Alcohol: Number of drinks/day_____

Tobacco: Packs per day_____ How many years_____

Previous smoker? _____ Date Quit: _____

Recreational Drug use: Intranasal Intravenous Inhaled Swallowed

Single? Married? Widowed? Partnered? Divorced? Separated?

Gay? Lesbian? Transgendered? Bisexual?

Number of children and
ages:_____
_____

History of physical abuse? Sexual abuse? Emotional abuse?

I have completed: Elementary school? Junior High High School College Grad school

Current occupation?_____

Exposures to
chemicals?_____
_____

Is there anything else you would like to discuss with the doctor?

_____
_____
_____
_____
_____
_____
_____

Thank you for your time and effort. The doctor will be out to get you shortly.