GRANGER MEDICAL CLINIC

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Neurology

New Patient Questionnaire

Patient Name: _____ Date: _____ Acct.#: _____

DOB: _____ Age: _____ ☐ Right - Handed ☐ Left - Handed

Referring Physician: _____ Primary Care Physician: _____

Have you ever seen a Neurologist? ☐ Yes ☐ No If yes, when? _____ Who was the Neurologist? _____

Have you had any neurological scans? ☐ CT ☐ MRI If yes, where? _____

Chief Complaint: _____

_____

History of Present Illness: _____

_____

Current Medications

Please list ALL medications you are currently taking, including over-the-counter, vitamins, and supplements:

_____

_____

_____

_____

Drug Allergies: _____

Surgical History

Please list any surgeries you have had: _____

Have you ever been in the hospital over night for a Neurological condition? (This does not include ER visits.) ☐ Yes ☐ No

If yes, what was the reason? _____

Please list which hospital and the approximate date(s): _____

Medical History (please check all that apply)

☐ Allergy/ Hay Fever	☐ CNS Malignancy	☐ Fibromyalgia	☐ High Blood Pressure
☐ Anemia	☐ Chronic Polyps	☐ Genitourinary Disease	☐ High Cholesterol
☐ Arthritis	☐ Congestive Heart Failure	☐ GERD	☐ HIV
☐ Asthma	☐ Depression/ Anxiety	☐ Headache/ Migraine	☐ Irregular Heart Beat
☐ Bleeding Disorder	☐ Dermatology Disorder	☐ Headache/ Tension	☐ Liver Disease/ Hepatitis
☐ Cervical Spine Disease	☐ Diabetes	☐ Head Injury	☐ Lumbar Spine Disease
☐ Chronic Fatigue	☐ Endocrine Disease	☐ Heart Attack	☐ Macular Degeneration
☐ Chronic Obstructive Pulmonary Cancer	☐ Epilepsy/ Seizures	☐ Heart Disease	☐ Menstrual Sexual Dysfunction
☐ Murmur	☐ Peripheral Vascular Disease	☐ Renal Disease	☐ Thyroid Disease
☐ Nerve Muscle Disease	☐ Pneumonia	☐ Rheumatic Fever	☐ Tremor
☐ Peptic Ulcer	☐ Polio	☐ Spinal Cord Injury	☐ Tuberculosis
☐ Peripheral Nerve	☐ Pulmonary Embolism	☐ Stroke	☐ Venereal Disease

Review of Systems (General)

☐ Cardiac	☐ Fatigue	☐ Hematologic	☐ Weight Loss/ gain
☐ Depression	☐ Fevers	☐ Musculoskeletal	
☐ Dermatological	☐ Gastrointestinal	☐ Peripheral Vascular	
☐ Ear/Nose/Throat	☐ Genitourinary	☐ Respiratory	

Review of Systems (Neurologic)

☐ Blurred Vision	☐ Difficulty in Tasting	☐ Lethargy	☐ Poor Balance
☐ Bowel Changes	☐ Difficulty in Walking	☐ Loss of Bladder Control	☐ Poor Coordination
☐ Changes in Vision	☐ Dizziness	☐ Loss of Consciousness	☐ Ringing in Ears
☐ Choking	☐ Double Vision	☐ Loss of Vision (R or L, Eye)	☐ Weakness in Legs (R or L)
☐ Concentration	☐ Drooling	☐ Memory	☐ Spinning Sensation
☐ Confusion	☐ Facial Numbness/Tingling	☐ Nausea/ Vomiting	☐ Stiffness
☐ Difficulty in Chewing	☐ Hallucinations	☐ Numbness in Arms (R or L)	☐ Tremor
☐ Difficulty in Smelling	☐ Headache	☐ Numbness in Legs (R or L)	☐ Weakness in Arms (R or L)
☐ Difficulty in Speaking	☐ Hearing Loss (R or L, Ear)	☐ Pain Spells	☐ Weakness in Legs (R or L)
☐ Difficulty in Swallowing	☐ Hoarseness	☐ Personality Changes	

Family History

	Father	Mother	Fathers Parents	Mothers Parents	Siblings	Children
Cancer						
CNS Tumors						
Dementia						
Diabetes						
Heart Disease						
High Blood Pressure						
Migraine						
Neuromuscular						
Stroke						
Thyroid Disease						
Tremor						

Social History: ☐ Married ☐ Single ☐ Partner ☐ Divorced ☐ Widowed Number of Children _____ Age(s) _____

Occupation: _____ Retired? ☐ Yes ☐ No

Do you smoke tobacco? ☐ Yes ☐ No If yes, how much? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Other Drug use (past or present): _____