NY Neurological Associates, P.C.

NEW PATIENT MEDICAL HISTORY

To help us focus during your visit, please fill out the FRONT AND BACK of this form as completely as possible.

Name					
Today's Date		**Date of birth**			
Primary Doctor					
Other Neurologist(s) you have seen					
Occupation		**Education**			
I live:	Alone ☐	With:			
Marital Status	◯ Single	◯ Married	◯ Widowed	◯ Divorced	◯ Separated

WHAT IS THE REASON FOR TODAY'S VISIT? WHY DID YOUR DOCTOR REFER YOU FOR NEUROLOGICAL EVALUATION?

PAST MEDICAL AND SURGICAL HISTORY
Please include 1. medical problems such as diabetes, hypertension, 2. hospitalizations, and 3. Surgeries

***ALLERGIES* to medications ☐NONE Name _____Reaction_____**

***CURRENT MEDICATIONS* (please include names and doses and when it was started):**

Do you smoke? ☐**Yes How many cigarettes per day?_____** ☐**Quit** ☐**Never**

Do you drink alcohol? ☐**Yes How many drinks per week_____** ☐**Never**

Are you RIGHT handed or LEFT handed? **(Select one)**

☐ ☐

NAME_____**DOB**_____

FAMILY HISTORY

RELATION	Alive/ Deceased	AGE	Has a problem similar to mine	All known health problems
MOTHER				
FATHER				
BROTHERS				
SISTERS				
CHILDREN				
OTHERS				

SYMPTOM REVIEW Please check off the symptom(s) that you have *recently* experienced.
Please check "None of the above" if applicable.

Constitutional
- ☐ Excess weight gain
- ☐ Excess weight loss
- ☐ Loss of appetite
- ☐ Fever
- ☐ Low activity level
- ☐ Fatigue
- ☐ None of the above

Eyes
- ☐ Eye pain
- ☐ Blurry vision
- ☐ Eye redness
- ☐ Eye itchiness
- ☐ Eye swelling
- ☐ Eye discharge
- ☐ None of the above

Ears, Nose, Mouth,Throat
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Drooling
- ☐ Facial swelling
- ☐ Congestion
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Foul smelling breath
- ☐ Mouth lesions
- ☐ None of the above

Cardiovascular
- ☐ Chest pain
- ☐ Rapid heart rate
- ☐ None of the above

Respiratory
- ☐ Cough
- ☐ Bark like cough
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Pain with respiration
- ☐ Noisy breathing
- ☐ Rapid respiration
- ☐ Difficulty breathing

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Blood in stools
- ☐ Mucus in stools
- ☐ None of the above

Genito-urinary
- ☐ Discharge
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ urinary frequency
- ☐ urinary urgency
- ☐ None of the above

Musculoskeletal
- ☐ Soft tissue swelling
- ☐ Joint swelling
- ☐ Myalgia
- ☐ Limited motion
- ☐ Previous injuries
- ☐ Trauma
- ☐ None of the above

Neurological
- ☐ Numbness
- ☐ Weakness
- ☐ Tingling
- ☐ Burning
- ☐ Shooting pain
- ☐ Headache
- ☐ Dizziness
- ☐ Loss of consciousness
- ☐ None of the above

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Insomnia
- ☐ Stress
- ☐ Loss of interest
- ☐ None of the above

O**ther things your doctor should know about you:**

Patient signature:	**Reviewed by doctor:** **Date:**