Name: **ACCT#:** **Noran Neurology Provider:**

DOB: **Age:** **Gender:**

What symptoms or neurologic condition are you being seen for today?
List:

Do you have any other new medical conditions? Yes No **Pregnant?** Yes No
List:

Have you been to the ER or hospitalized recently? Yes No **Recent Surgery?** Yes No
Details:

Have you had any recent changes in your job or family? Yes No
Details:

Are there any recent changes in your family's health? Yes No
Details:

Review of symptoms (mark below all that apply):

Head

__ headache

__ loss of vision

__ spinning dizziness

__ light headedness

Other Neurologic

__ difficulty concentrating

__ memory loss

__ trouble walking

__ falling

__ arm weakness

__ leg weakness

__ numbness / tingling

__ shaking / tremor

Other

__

Musculoskeletal

__ neck pain

__ mid back pain

__ low back pain

__ shoulder pain

__ knee pain

__ other joint pain

Psychiatric

__ depression

__ anxiety

Cardiovascular

__ palpitations

__ swelling of feet

Respiratory

__ shortness of breath

Gastrointestinal

__ vomiting

__ loss of bowel control

Genitourinary

__ frequent urination

__ loss of bladder control

Hematologic/Lymphatic

__ bleeding tendency

__ blood clots

Skin

__ rash

__ hair loss

General

__ weight loss

__ weight gain

Sleep

__ snoring

__ choking/gasping in sleep

__ daytime sleepiness

__ morning headaches

__ waking feeling unrefreshed

__ difficulty falling asleep

__ aching/crawling sensation in legs

__ neck size 17 inches or larger

Circle the number that relates to your overall level of pain **today**:
(none) 1 2 3 4 5 6 7 8 9 10 (worst)

Signature: _____ **Date:** _____

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Past Medical History: mark below all that apply to you

__ Anemia	__ Chemical dependency	__ High blood pressure	__ Sleep apnea
__ Angina	__ Deep vein thrombosis	__ High Cholesterol	__ Stroke / TIA
__ Anxiety Disorder	__ Depression	__ HIV / AIDS	__ Systemic lupus
__ Arthritis	__ Diabetes	__ Kidney problems	__ Thyroid disease
__ Arrhythmia	__ Epilepsy / seizures	__ Multiple sclerosis	__ Ulcers
__ Asthma	__ Glaucoma	__ Neuropathy	
__ Atrial fibrillation	__ Heart attack	__ Pacemaker	__ _____
__ Bipolar disorder	__ Heart failure	__ Parkinson's Disease	__ _____
__ Cancer / Tumor	__ Hepatitis	__ Rheumatoid arthritis	

Past Surgeries: write below your past surgeries and approximate year ❑ none

Past Injuries: write below your injuries and approximate date ❑ none

Medications: list drugs and dosing (if known) below

Allergies: list drugs and reaction below

Social History:

Education: How many years of school have you completed? _____ Are you in school now? ❑ yes ❑ no

Are work hours restricted? ❑ yes ❑ no

Other restrictions? (List)

If not working: When did you last work? _____ When might you return to work? _____

Occupation(s): _____ Handedness: ❑ right ❑ left

Military history? ❑ none ❑ current ❑ previous

Marital status: ❑ single ❑ partnered ❑ married ❑ separated ❑ divorced ❑ widowed

Number of children: _____

Tobacco use: ❑ Never Smoked ❑ Previous smoker, if quit, year quit? _____ ❑ Current Smoker, how much? _____

How often? _____ ❑ Unknown if ever smoked

Alcohol use: ❑ yes ❑ no Amount and frequency? _____ If quit, when? _____

Caffeine use: ❑ yes ❑ no Amount and frequency? _____ If quit, when? _____

Family History: mark below if a close relative (mother, father, sister, brother, child) has had any of the following problems:

Problem	Relative	Problem	Relative
Attention deficit disorder		Mental illness	
Alzheimer's disease/dementia		Multiple sclerosis	
Birth defect		Muscle disease	
Brain tumor		Neuropathy	
Brain aneurysm		Parkinson's disease	
Difficulty walking		Stroke	
Epilepsy/seizures		Tics/Tourette's	
Headaches/migraines		Tremor	
Huntington's chorea		Other neurologic	
Intellectual disability			

Mother: ❑ living ❑ deceased Father: ❑ living ❑ deceased

Name:	**ACCT#:**	**Noran Neurology Provider:**
DOB:	**Age:**	**Gender:**

If you are having pain or numbness:
Shade in areas of pain or numbness below: