

Date: _____

New Patient Data Sheet

1. Patient information:

Name _____ Age _____ Sex _____ DOB _____

2. Referred by: ___Physician (Name) _____

___Family/Friend (Name) _____ ___Self

3. Chief complaints: (check which applies, or write on item 3.12)

3.1. **Headaches** (Please fill out headache sheet)

3.2. **Seizures** (Please fill out seizure sheet)

3.3. **Numbness/tingling** ___Arms (L R) ___Legs (L R) ___Face (L R) ___Other _____

3.4. **Muscle weakness** ___Arms (L R) ___Legs (L R) ___Face (L R) ___Other _____

3.5. **Pain:** ___Lower back ___Neck ___Mid back ___Arms (L R) ___Legs (L R) ___Face (L R)

___All over Other _____

3.6. **Tremor:** ___Hands (L R) ___Legs (L R) ___Head ___Other _____

If Parkinson's Disease: Symptoms started _____(mm/yy) Diagnosed on _____(mm/yy)

Affecting your ___Hands (L R) ___Head ___Legs (L R) ___Daily activities ___Other _____

3.7. **Stroke/TIA:** Symptoms started _____(mm/yy) Affecting your ___Arms (L R) ___Legs (L R)

___Face (L R) ___Vision ___Other _____

3.8. **MS:** Symptoms started _____(mm/yy) Affecting your ___Arms (L R) ___Legs (L R)

___Face (L R) ___Vision ___Other _____

3.9. **Walking Problems:** ___Off balance ___Frequent falls ___Foot drop (L R) ___Small steps

___Slow turning ___Other _____

3.10. **Dizziness:** ___Light headedness ___Spinning/rocking sensation ___Associated w/nausea/vomiting

___Passing out ___Other _____

3.11. **Sleep Problems:** ___Difficulty falling asleep ___Difficulty staying asleep ___Loud snoring

___Stop breathing during sleep ___Other _____

3.12. **Other** _____

4. List all the **medications** you currently are taking (including doses and frequency):

1 _____ 5 _____

2 _____ 6 _____

3 _____ 7 _____

4 _____ 8 _____

5. List all meds you are **allergic** to:

1 _____ 3 _____

2 _____ 4 _____

Date: _____

Neurology & Acupuncture Clinic
1520 Breezport Way Suite 600
Suffolk, VA 23435

Name: _____

6. Have you had the following medical problems (check which applies):

- | | | | |
|---|--|--|---|
| <input type="checkbox"/> ADHD | <input type="checkbox"/> Headaches: migraine, tension, cluster, post-traumatic | <input type="checkbox"/> MS | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> ALS | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Muscular dystrophy | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Myasthenia Gravis | <input type="checkbox"/> Spinal stenosis/spondylosis (Lumbar, Cervical) |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Neuropathy (specify _____) | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Parkinson's disease | <input type="checkbox"/> Subdural hematoma |
| <input type="checkbox"/> Bipolar | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Peptic ulcer diseases | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Cardiac Arrhythmias | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> COPD (Emphysema) | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Polymyositis | <input type="checkbox"/> TIA (mini stroke) |
| <input type="checkbox"/> Coronary artery disease | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Renal disease (specify _____) | <input type="checkbox"/> Trigeminal neuralgia |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Intracranial aneurysms | <input type="checkbox"/> Sarcoidosis (specify _____) | <input type="checkbox"/> Tumor/cancer |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Lupus | <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> UTI |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Seizure disorders | <input type="checkbox"/> Vascular disease |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Meningitis | | |
| <input type="checkbox"/> Gastroesophageal Reflux Disease (GERD) | | | |

Others _____

7. List all the **surgeries and dates** you have had (past surgical history):

- | | |
|----|----|
| 1. | 4. |
| 2. | 5. |
| 3. | 6. |

8. **Review of Systems:** (Circle which applies)

General: Fatigue Weight gain weight loss other _____

Respiratory: Chronic Cough Difficulty breathing Wheezing Snoring other _____

Cardiovascular: Chest Pain Fainting Palpitations Shortness of breath Ankle edema other _____

Gastrointestinal: Heart burn Abdominal pain Nausea Vomiting Diarrhea other _____

Neurological: Tingling Numbness Headaches Speech difficulty Memory impairment

Seizures Stroke Tremor Muscle Weakness Visual loss Double vision Hearing loss

Gait disturbances Dizziness Head injury Urinary incontinence

Other _____

Musculoskeletal: Low back pain Neck pain Joint pain Arthritis Pain all over other _____

Psychiatric: Anxiety Depression Suicidal ideation Insomnia Hallucination Agitation

Mood swings Confusion Poor concentration Inappropriate behavior other _____

Endocrine: Cold intolerance Heat intolerance Hot flashes Menopause Appetite change other _____

Skin: Easy bruising Rash Change in wart/mole other _____

Hematology: Abnormal bleeding Blood clots Anemia other _____

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9. **Diagnostic Studies** and dates (circle which applies):

MRI: Brain C-Spine T-Spine L-Spine other _____

CT: Head other _____ EEG _____

EMG: _____ Lumbar Puncture _____

VEP _____ Other _____

10. List diagnosed diseases in your family (**Family History**):

Mother _____

Father _____

Siblings _____

Others _____

11. **Social History:**

Are you married single divorced widow/widower separated

Your occupation _____ F/T P/T Disabled

Do you live alone with your spouse with others _____

Do (have) you smoke(d)? Yes No Occasionally

If yes, (how many) _____ packs/day for (how many) _____ years. Quit _____ (mm/year)

Do (have) you drink (drunk) alcohol? Yes No Occasionally

If yes, (how many) _____ wine/beers/liquors/others per day/week/year for (how many) _____ years.

Quit _____ (mm/year)

Have you ever used any illegal drugs before? Yes No

If yes, what _____ Last time used _____ (mm/year)

12. PCP Name: _____ PCP phone number: _____

13. Pharmacy Name: _____ Pharmacy Number: _____