

PRIMED PHYSICIANS

NEUROLOGY

MEDICAL REVIEW OF SYMPTOMS

Patient Name _____

DOB _____ Occupation _____

Primary Care Physicians Name/Telephone _____

Date of Last Physical Exam _____ Are you currently under a doctor's care? _____

If yes, which Physician(s) _____

Have you ever had any of the following conditions? Please check YES or NO. Your answers will be treated as strictly confidential medical information.

<u>Heart or Circulatory</u>	Yes	No
Heart Attack	<input type="radio"/>	<input type="radio"/>
Heart Failure	<input type="radio"/>	<input type="radio"/>
Irregular Heart Rhythm	<input type="radio"/>	<input type="radio"/>
Palpitations	<input type="radio"/>	<input type="radio"/>
Heart Murmur	<input type="radio"/>	<input type="radio"/>
Chest Pain	<input type="radio"/>	<input type="radio"/>
High Blood Pressure	<input type="radio"/>	<input type="radio"/>

<u>Ear, Nose, and Throat</u>	Yes	No
Frequent Ear Infections	<input type="radio"/>	<input type="radio"/>
Hearing Loss	<input type="radio"/>	<input type="radio"/>
Ringing in the ears	<input type="radio"/>	<input type="radio"/>
Nasal Allergies	<input type="radio"/>	<input type="radio"/>
Respiratory Allergies	<input type="radio"/>	<input type="radio"/>

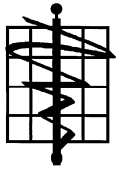
<u>Neurologic/Head</u>	Yes	No
Chronic headaches	<input type="radio"/>	<input type="radio"/>
Frequent headaches	<input type="radio"/>	<input type="radio"/>
Loss of consciousness	<input type="radio"/>	<input type="radio"/>
Epilepsy/seizure	<input type="radio"/>	<input type="radio"/>
Brain Tumor	<input type="radio"/>	<input type="radio"/>
Brain hemorrhage	<input type="radio"/>	<input type="radio"/>
Imbalance/coordination	<input type="radio"/>	<input type="radio"/>
Trouble with Speech	<input type="radio"/>	<input type="radio"/>
Double vision	<input type="radio"/>	<input type="radio"/>
Weakness of arms/legs	<input type="radio"/>	<input type="radio"/>
Numbness/Tingling (persistent)	<input type="radio"/>	<input type="radio"/>
Loss of vision (sudden/severe)	<input type="radio"/>	<input type="radio"/>

<u>Respiratory</u>	Yes	No
Asthma	<input type="radio"/>	<input type="radio"/>
Shortness of Breath	<input type="radio"/>	<input type="radio"/>
Chronic Cough	<input type="radio"/>	<input type="radio"/>
Coughing up Blood	<input type="radio"/>	<input type="radio"/>
Emphysema	<input type="radio"/>	<input type="radio"/>
Do you smoke?	<input type="radio"/>	<input type="radio"/>
For how many years _____ PPD _____		

<u>Musculoskeletal</u>	Yes	No
Arthritis/Rheumatism	<input type="radio"/>	<input type="radio"/>
Chronic Muscle Ache	<input type="radio"/>	<input type="radio"/>
Herniated/Slipped disc	<input type="radio"/>	<input type="radio"/>
Fractured Bones	<input type="radio"/>	<input type="radio"/>
Fatigue Easily	<input type="radio"/>	<input type="radio"/>
Pain or tender scalp	<input type="radio"/>	<input type="radio"/>
Pain with chewing	<input type="radio"/>	<input type="radio"/>

<u>Skin</u>	Yes	No
Persistent. Chronic rash	<input type="radio"/>	<input type="radio"/>
Skin Tumor	<input type="radio"/>	<input type="radio"/>
Other skin problems	<input type="radio"/>	<input type="radio"/>

<u>Blood/Lymphatic</u>	Yes	No
Anemia	<input type="radio"/>	<input type="radio"/>
Leukemia	<input type="radio"/>	<input type="radio"/>
Bleeding tendency	<input type="radio"/>	<input type="radio"/>
Clotting tendency(thrombosis)	<input type="radio"/>	<input type="radio"/>
Swollen lymph nodes/glands	<input type="radio"/>	<input type="radio"/>



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Endocrine/Hormonal Yes No
 Diabetes O O
 Thyroid Disease O O
 Disease of Endocrine Glands O O
 (pituitary, adrenal, pancreas, thyroid, parathyroid)

Breast
 Breast lumps O O
 Breast Cancer O O

Allergic/immunological/infections
 Unusual susceptibility to infections O O
 Frequent or persistent fever O O
 Tuberculosis O O
 VD (sexually transmitted) O O
 AIDS/ARC/HIV O O
 Hepatitis O O

Cancer
 Cancer of any type O O
 Chemotherapy O O
 Radiation therapy O O

Kidney Yes No
 Kidney Disease O O
 Urinary tract infection O O

For Women Only
 Are you pregnant O O
 Have you had any childbirth complications? O O

Gastrointestinal
 Diarrhea O O
 Bloody bowel movements O O
 Constipation O O
 Abdominal pain/cramps O O
 Difficulty swallowing O O
 Ulcer (peptic) O O
 Other Digestive Ailments O O

Please list any serious infections you now have or have has in the past, such as Lyme disease, Epstein Barr virus, Syphilis, Mononucleosis, HIV, Malaria, or Tropical Disease: _____

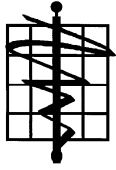
General Health
 Have you ever:
 Been addicted to drugs? _____
 Been addicted to alcohol? _____
 Had unexplained loss of
 Energy or strength? _____
 Unexplained weight or
 Appetite loss? _____
 Had chronic fever/swollen glands? _____
 Been hospitalized? _____

What is your weight? _____
 Do you have a pacemaker _____
 Are you claustrophobic? _____
 Do you have metal implants? _____

Psychiatric
 Severe depression _____
 Severe Mood Swings _____
 Medications for depression
 And/or anxiety? _____
 Treatment for psychiatric
 Disorder _____

Had Surgery? _____ If so, list each surgery with date: _____

Please list medication that you take, include the strength, and how many times a day you take them. Please include all pills, injections, patches, drops, aspirin, birth control, and vitamins _____



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Are you allergic to any medication? Please list any drug allergies and type of reaction: _____

Previous Testing: Have you had (if yes, state location and approximate date):

MRI or CT scan of head, eyes, or sinuses _____

VEP (visual evoked potential) _____

Cerebral Angiogram _____

Lumbar Puncture (spinal tap) _____