PriMED PHYSICIANS
Treating You Well.®

Neurology Medical Review of Symptoms

Patient Name _____ DOB _____/_____/____

Occupation _____

Primary Care Physician Name and Phone _____

Date of last Physical Exam _____/_____/_____ Currently under a doctor's care? **Yes** **No**

If Yes, Name of physician(s) _____

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

Heart or Circulatory	Y	N
Heart attack		
Heart failure		
Irregular heart rhythm		
Palpitations		
Heart Murmur		
Chest pain		
High blood pressure		

Respiratory	**Y**	**N**
Asthma		
Shortness of breath		
Chronic cough		
Coughing up blood		
Emphysema		
Do you smoke		
- For how many years_____ PPD _____		

Ears / Nose / Throat	Y	N
Frequent ear infections		
Hearing loss		
Ringing in the ears		
Nasal allergies		
Respiratory allergies		

Musculoskelatal	**Y**	**N**
Arthritis / Rheumatism		
Chronic muscle ache		
Herniated / slipped disc		
Fractured bones		
Fatigue easily		
Pain or tender scalp		
Pain when chewing		

Neurologic / Head	Y	N
Chronic headaches		
Frequent headaches		
Loss of consciousness		
Epilepsy / Seizures		
Brain tumor		
Brain hemorrhage		
Imbalance / coordination		
Trouble with speech		
Double vision		
Weakness of arms / legs		
Numbness, tingling (persistent)		
Loss of vision		

Skin	**Y**	**N**
Persistent, chronic rash		
Skin tumor		
Other skin problems		

Blood / Lymphatic		
Anemia		
Leukemia		
Bleeding tendency		
Clotting tendency (thrombosis)		
Swollen lymph nodes / glands		

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Endocrine / Hormonal	Y	N
Diabetes		
Thyroid Disease		
Disease of Endocrine Glands (pituitary, adrenal, pancreas, thyroid, parathyroid)		

Kidney	Y	N
Kidney Disease		
Urinary Tract Infection		

Breast	Y	N
Breast Lumps		
Breast Cancer		

Women Only	Y	N
Are you pregnant		
Any childbirth complications		

Allergic / Immunological / Infections	Y	N
Unusual susceptibility to infections		
Frequent or persistent fever		
Tuberculosis		
Venereal disease - sexual transmitted		
AIDS / ARC / HIV		
Hepatitis		

Gastrointestinal	Y	N
Diarrhea		
Bloody bowl movement		
Constipation		
Abdominal pain / cramps		
Difficulty swallowing		
Ulcer (peptic)		
Other digestive ailments		

Cancer	Y	N
Cancer of any type		
Chemotherapy		
Radiation therapy		

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

_____

_____

General Health:

Have you ever…	Y	N
Been addicted to drugs		
Been addicted to alcohol		
Had unexplained loss of energy / strength		
Had unexplained weight / appetite loss		
Had chronic fever / swollen glands		
Been hospitalized		
Had surgery		
- If so, list each surgery and dates below		

What is your weight		
Do you have a pacemaker		
Are you claustrophobic		
Do you have metal implants		
Psychiatric	**Y**	**N**
Severe depression		
Severe mood swings		
Medications for depression / anxiety		
Treatment for psychiatric disorder		

_____

_____

_____

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Please list all 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.

_____

_____

_____

_____

Are you allergic to any medication? YES NO

Please list any drug allergies and type of reaction: _____

_____

Previous Testing: If you have had any of the following, please state the location and approximate date.

MRI or CT scan of head, eyes, or sinuses

_____

VEP (visual evoked potential)

_____

Cerebral Angiogram

_____

Lumbar Puncture (spinal tap)

_____