Vaught
NEUROLOGICAL SERVICES

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Today's Date:_____

Patient Information Form

SSN _____ Guarantor SSN _____
(home) _____ email: _____
(work) _____ mailing address: _____
(cell) _____ _____
May we send **text message** appointment reminders? ☐ Yes ☐ No Test Results? ☐ Yes ☐ No
Emergency Contact: _____ Relationship to Emergency Contact:
_____ _____
Primary Care Physician: _____ **Referring Physician:** _____
What main symptom or problem brings you in today? _____
How long have you been having these symptoms? _____
Briefly describe how your symptoms have progressed: _____
_____

Medical History:

Check here if you have no medical problems: ☐

High Blood Pressure	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Heart attack or coronary artery disease	☐ Yes	☐ No
Pacemaker	☐ Yes	☐ No
Cardiac Stents	☐ Yes	☐ No
Stroke or TIA	☐ Yes	☐ No
Asthma	☐ Yes	☐ No
Hypothyroidism	☐ Yes	☐ No
Cancer	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No
Depression	☐ Yes	☐ No
Epilepsy	☐ Yes	☐ No
Implanted device (VNS, spinal stimulator, etc)	☐ Yes	☐ No
Kidney stones	☐ Yes	☐ No
Stomach Ulcers	☐ Yes	☐ No
High Cholesterol	☐ Yes	☐ No

Drug Allergies: _____
_____
_____

Please list other medical problems that you would like us to know about: _____
_____
_____

Your Surgeries:

Check here if you have never had any surgeries: ☐

Heart Surgery	☐ Yes	☐ No
Carotid Surgery	☐ Yes	☐ No
Appendectomy	☐ Yes	☐ No
Low Back Surgery	☐ Yes	☐ No
Gall Bladder Surgery	☐ Yes	☐ No
Neck Surgery	☐ Yes	☐ No
Gastric bypass	☐ Yes	☐ No
Tubal ligation "tubes tied"	☐ Yes	☐ No

Now, tell us a little about your immediate family members:

Does anyone in your immediate family have these same symptoms that you are seeing us for today?

☐ Yes ☐ No

Mother ☐ neuropathy ☐ headaches ☐ strokes ☐ tremors ☐ heart disease

Father ☐ neuropathy ☐ headaches ☐ strokes ☐ tremors ☐ heart disease

Siblings ☐ neuropathy ☐ headaches ☐ strokes ☐ tremors ☐ heart disease

Children ☐ neuropathy ☐ headaches ☐ strokes ☐ tremors ☐ heart disease

Your Lifestyle and Habit Information:

What is your marital status? ☐ single ☐ married ☐ divorced ☐ widowed

With whom do you live? ☐ alone ☐ spouse ☐ partner/friend ☐ family

Have you had any falls within the past year? ☐ None ☐ 1 without injury ☐ 2 or more without injury ☐ 1 with injury ☐ 1 or more with injury

Do you smoke? ☐ Yes ☐ No ☐ Used to smoke but quit

Did you have a drink containing alcohol in the past year? ☐ Yes ☐ No

How much **caffeine (coffee, soda, tea)** do you drink per day?

☐ none ☐ 1-2 cups ☐ 2-4 cups ☐ more than 4 cups

Do you currently use **illegal/street drugs**? ☐ No ☐ marijuana ☐ cocaine/crack ☐ _____

Are you currently working? ☐ Yes ☐ No ☐ Homemaker ☐ Retired ☐ Disabled ☐ Student

Current or former occupation: _____

Thank you. We will call you back for your appointment shortly.

Review of Systems Questionnaire

On this page, check the box of any significant symptoms that you have been having:

Fever	☐		Joint pain	☐	
Fatigue	☐		Joint swelling	☐	
Night Sweats	☐		Dry skin	☐	
Double vision	☐		Headache	☐	
Flashes	☐		Tingling	☐	
Blind Spots	☐		Numbness	☐	
Blurring vision	☐		Seizure	☐	
Vision change	☐		Dizziness	☐	
Hearing loss	☐		Memory problems	☐	
Voice change	☐		Tremors	☐	
Sore throat	☐		Depression	☐	
Ringing in ears	☐		Tension/stress	☐	
Shortness of breath	☐		Anxiety	☐	
Sinus problems	☐		Sleep disturbance	☐	
Cough	☐		Hallucinations	☐	
Drooling	☐		Excessive thirst	☐	
Chest pain	☐		Heat intolerance	☐	
Palpitations	☐		Cold intolerance	☐	
Leg swelling	☐		Easy bruising	☐	
Diarrhea	☐		Blood transfusion	☐	
Constipation	☐		Drug Allergies	☐	
Difficulty swallowing	☐		Season Allergies	☐	
Stool Incontinence	☐		Latex Allergy	☐	
Joint stiffness	☐		Urinary Incontinence	☐	
Leg cramps	☐		Hurt to urinate?	☐	
Weight changes?	☐		Sexual symptoms?	☐	

Additional Notes: _____

_____

_____

_____

If any of the above symptoms aren't discussed during your consultation in the clinic, please discuss them with your primary care doctor if you haven't already done so.

Patient Signature: _____ Date: _____

MD/NP/PA Signature: _____ Date: _____