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: _____