Vaught
NEUROLOGICAL SERVICES

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Patient Information Form

First Appointment Date: _____
Contact Info:

(home) _____ **email**: _____

(work) _____ May we send you emails? O Yes O No

(cell) _____

May we send **text message** appointment reminders? O Yes O No

Emergency Contact: _____

_____

Primary Care Provider: _____ **Referring Provider**:_____

1. Please complete all sections, there are 3 pages total.
2. Fill in the circle beside your answer completely with dark marks.
3. Hand the form back to the receptionist once completed.
4. Relax, you are amongst friends.

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: O

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

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

	O Yes	O No			
Mother	O neuropathy	O headaches	O strokes	O tremors	O other
Father	O neuropathy	O headaches	O strokes	O tremors	O other
Brothers/Sisters	O neuropathy	O headaches	O strokes	O tremors	O other
Children	O neuropathy	O headaches	O strokes	O tremors	O other

Your Lifestyle and Habit Information:

What is your marital status? O single O married O divorced O widowed O other

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

Do you **smoke**? O Yes O No O Used to smoke but quit

How much **alcohol** do you drink? O None/Never O Rarely/Occasionally O 1-2 per day
(beer,wine, liquor) O more than 2 per day

How much **caffeine (coffee, soda, tea)** do you drink per day?
O none O 1-2 cups O 2-4 cups O more than 4 cups

Do you currently use **illegal/ street drugs**? O No O marijuana O cocaine/crack O other

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

Current or former occupation: _____

Hang in there, just one more page…..

.

On this page, tell us about significant symptoms that you have been having recently:

Weight change	O none O gain	O loss
Fever	O Yes	O No
Fatigue	O Yes	O No
Night sweats	O Yes	O No
Double Vision	O Yes	O No
Flashes or blind spots	O Yes	O No
Blurring of vision	O Yes	O No
Changes in vision	O Yes	O No
Hearing loss	O Yes	O No
Change in voice	O Yes	O No
Sore throat	O Yes	O No
Ringing in ears	O Yes	O No
Shortness of breath	O Yes	O No
Sinus problems	O Yes	O No
Cough	O Yes	O No
Drooling	O Yes	O No
Chest pain	O Yes	O No
Palpitations	O Yes	O No
Leg swelling	O Yes	O No
Diarrhea	O Yes	O No
Constipation	O Yes	O No
Difficulty swallowing	O Yes	O No
Stool Incontinence	O Yes	O No
Joint stiffness	O Yes	O No
Leg cramps	O Yes	O No
Joint pain	O Yes	O No
Joint swelling	O Yes	O No
Dry skin	O Yes	O No
Headache	O Yes	O No
Tingling or numbness	O Yes	O No
Seizure	O Yes	O No
Dizziness	O Yes	O No
Memory problems	O Yes	O No
Tremors	O Yes	O No
Depression	O Yes	O No
Tension/stress	O Yes	O No
Sleep disturbances	O Yes	O No
Anxiety	O Yes	O No
Hallucinations	O Yes	O No
Excessive thirst	O Yes	O No
Heat intolerance	O Yes	O No
Cold intolerance	O Yes	O No
Easy bruising	O Yes	O No
Blood transfusion	O Yes	O No
Drug Allergies	O Yes	O No (if so, be sure it's listed on page 1)
Hayfever/ Seasonal Allergies	O Yes	O No
Latex Allergy	O Yes	O No
Urinary Incontinence	O Yes	O No
Does it hurt to urinate?	O Yes	O No
Any problems with sexual function?	O Yes	O No

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.

Please return to the receptionist or nurse.
Thanks so much for coming to see us.
We will get started with your consultation soon.

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