Lehigh Neurology

This is confidential information. The answers to these questions will be helpful in your neurological evaluation and future care.

Name:				
Last	First	Middle	Age	Date of Birth
Address:				
Street		City	State	Zip Code
Phone: ()	()	()_	
Home		Work		Cell
Your PHYSICIANS	ľ	Name	Phone Number	
Referring Doctor				
Primary Care Doctor				
Specialist Doctor				
Your Pharmacy (*Impo Name:		_Address:		
Phone: ()		Fax: ()	
NEUROLOGICAL PROI	BLEM			
(Reason for visit today)			Date of	Examination

Past Medical History (Please give date of onset if it applies to you)

Disorders of the Heart	
Cardiac arrhythmia	
Myocardial infarction/heart attack	
Congestive heart failure	
Rheumatic fever	
Disorder of the heart valves	
Vascular Disorders	
Hypertension	
Atherosclerosis	
Stroke/mini stroke/TIA	
Aneurysm	
Carotid blockage/injury	
Poor circulation legs/arms	
Vasculitis (inflammation of arteries)	
Disorders of Respiration	
Asthma	
Emphysema	
Bronchitis	
Pulmonary hypertension	
Pulmonary embolism	
Rheumatologic Disorders	
Osteoarthritis	
Rheumatoid arthritis	
Systematic Lupus	
Sjogrens Syndrome	
Fibromyalgia	
Herniated vertebral disc	
Gout	
Kidney & Urinary Disorders	
Kidney failure (acute)	
Kidney failure (chronic)	
Kidney stones	
Urinary tract infections	
CI' P' I	
Skin Disorders	
Recurrent rash	
Psoriasis or Eczema Genital/mouth/foot ulcer	
Genital/mouth/100t ulcer	

Gastrointestinal Disorders	
Ulcer (stomach, mouth, rectum)	
Inflammatory Bowel	
Irritable Bowel	
Cirrhosis/Hepatitis Liver	
Pancreatitis/Cholecystitis (Gall Bladder)	
Gastrointestinal bleeding	
Hormone and Metabolism	
Diabetes Mellitus	
Thyroid Disease	
Parathyroid Disease	
High Cholesterol	
Osteoporosis	
B12 deficiency	
Vertebral compression fracture	
Cancer or Blood Disorder	
Site of Cancer	
Chronic Anemia	
Leukemia/Lymphoma	
Chronic Infections	
Lung/Liver/Heart/Kidney	
Ear/Nose/Throat/Sinus/Skin	
HIV	
TB	
Sarcoid	
Herpes	
Fungal	
Neurologic/Psychological Disorders	
Seizures or Epilepsy	
Pituitary or Brain Tumor	
Recurrent head or face pain	
Concussion or spinal trauma	
Huntington Disease	
Neuropathy	
Meningitis/Encephalitis	
Muscle Disease/Dystrophy	
ALS, Myasthenia Gravis, PMR	
Depression	
Obsessive Compulsive Disorder	
Hyperactivity Attention Deficit	
Parkinson's Disease	
Multiple Sclerosis	
Alzheimer's Disease	
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List All Hospitalizations and Surgeries

Date Reason for Hospitalization/Surgery Location **List Current Medications/Vitamins/Supplements Frequency of Use** Name of Medication Mg or Mcg Dose **Medication Allergies/Bad Reactions:**

Social History:

Tobacco use: _				
	Type used	Year started	Amount daily	Quit? (year)
Alcohol use: _	Type used	Year started	Amount daily	Quit2 (voar)
	Type used	rear started	Amount dany	Quit: (year)
Did you ever w	ork outside the	home? Yes No		
Present or pre	vious occupation	as:		
Retirement if a	applicable: (age)	Disability	y if applicable: (age)
Marital Status	:	Occupational toxic expo	osure:	
Next of kin (ทย	nme and address	if different from yours)		
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Family Health History

Family Member	Living or Deceased	Health Good, Fair, Poor	Health Problems	Present Age or Age at Death	Cause of Death if Known
Father					
Mother					
Brothers Sisters					
M F					
M F					
M F					
M F					
M F					
M F					
Children					
M F					
M F					
M F					
M F					
M F					

Other Symptoms:
Doctors Notes on the Chief Neurological Complaint: