Patient Name________________________________ Date____/____/____

DOB____/_____/______

Jan Mashman, M.D.
Martin Kremenitzer, M.D.
Robert Bonwetsch, M.D.
Julie Waight, APRN
Diane Wirz, M.D.
John Murphy, M.D.
Joan Ellen Gereg, APRN
Steven Brown, Psy.D.
Samuel Markind, M.D.
Neil Culligan, M.D.
Stephen Peters, Psy. D
Anna Alshansky, M.D.
David Greco, M.D
Rebecca Smart, APRN
Michelle Bobulinski, Ph.D

Referring Physician: ____

Primary Physician: ____ **Your Age**: ______________

Chief Complaint **(Why were you referred to Associated Neurologists)?** ______________________________________

HPI (History of Present Illness)

❑ Location	
❑ Quality	
❑ Severity	
❑ Duration	
❑ Timing	
❑ Context	
❑ Modifying Factors	
❑ Assoc. Signs/ Symptoms	

PMH (Past Medical History)

Document Prior:	
❑ Major Illnesses	
❑ Operations	
❑ Hospitaliza-tions	

Medications (List all medications you are currently taking)	**Drug**	**Dose (mg)**	**Frequency**

Medication Allergies:____ Please state "none" if no allergies to medications

Please see other side

Patient Name______________________________ Date____/____/____

Social History:

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow(er) **Alcohol**: ☐ No ☐ Yes Amount: __________

Education: ______________________________ **Tobacco**: ☐ No ☐ Yes Amount: __________

Occupation: ______________________________

Other Information: ____

Family History:

	Age (Currently or at death)	**State of Health** (Indicate if deceased)	**Significant Disease or Illnesses** (If deceased, indicate cause of death)
Mother			
Father			
Brothers			
Sisters			
Children			

REVIEW OF SYSTEMS

Please check all that apply

1. Constitutional ☐ Negative
- ☐ Feeling tired or poorly
- ☐ Fever
- ☐ Recent change in weight

2. Eyes ☐ Negative
- ☐ Loss of part of field of vision
- ☐ White/light spots in field of vision
- ☐ Seeing double images
- ☐ Blurry vision

3. Ears, Nose, Mouth Throat ☐ Negative
- ☐ Loss of hearing
- ☐ Earache
- ☐ Discharge from the ears
- ☐ Nosebleeds
- ☐ Choking

4. Cardiovascular ☐ Negative
- ☐ Chest pain or discomfort
- ☐ Palpitations
- ☐ Difficulty breathing
- ☐ Shortness of breath

5. Respiratory ☐ Negative
- ☐ Cough
- ☐ Wheezing
- ☐ Difficulty swallowing

6. Gastrointestinal ☐ Negative
- ☐ Nausea
- ☐ Vomiting
- ☐ Change in the stool
- ☐ Diarrhea
- ☐ Constipation

7. Genitourinary ☐ Negative
- ☐ Burning sensation during urination
- ☐ Urinary loss of control
- ☐ Urinary frequency
- ☐ Blood in urine

8. Musculoskeletal ☐ Negative
- ☐ Joint pains
- ☐ Bone pain
- ☐ Lower back pain
- ☐ Neck pain

9. Integumentary (Skin) ☐ Negative
- ☐ Itching
- ☐ Unusual growth on skin

10. Neurological ☐ Negative
- ☐ Headache
- ☐ Numbness
- ☐ Tingling
- ☐ Difficulty walking
- ☐ Walk is wobbly or unsteady

11. Psychiatric ☐ Negative
- ☐ Depression
- ☐ Anxiety
- ☐ Unreasonable or irrational fears

12. Endocrine ☐ Negative
- ☐ Excessive thirst/fluid intake
- ☐ Temperature intolerance to heat
- ☐ Temperature intolerance to cold

13. Hematological / Lymph ☐ Negative
- ☐ Easy bruising
- ☐ Easy bleeding