Weill-Cornell Physicians Organization/NY Neurological Associates PC
PATIENT HISTORY

To better serve you during your office visit today, please fill out the FRONT AND BACK of this form as completely as possible. If your history and symptom review is unchanged since the last visit, please INITIAL AT THE BOTTOM OF BOTH PAGES.

Name					
Today's Date			**Date of birth**		
Primary Doctor					
Other Neurologist(s) you have seen					
Occupation			**Education**		
I live: (circle)	Alone	With:			
Marital Status (circle)	Single	Married	Widowed	Divorced	Separated

WHAT IS THE REASON FOR TODAY'S VISIT? WHY DID YOUR DOCTOR REFER YOU FOR NEUROLOGICAL EVALUATION?

PAST MEDICAL AND SURGICAL HISTORY

Please include 1. medical problems such as diabetes, hypertension, 2. hospitalizations, and 3. Surgeries

*****ALLERGIES*** **to medications ☐NONE Name ____________________________Reaction___________________________**

CURRENT MEDICATIONS **(please include names and doses and when it was started):**

Do you smoke? **☐Yes How many cigarettes per day?___________________ ☐Quit ☐Never**

Do you drink alcohol? **☐Yes How many drinks per week________________ ☐Never**

PLEASE COMPLETE THE OTHER SIDE*

***PLEASE INITIAL HERE IF ABOVE INFORMATION UNCHANGED FROM PRIOR VISIT:** ☐

NAME_________________________________**DOB**____________________

***Are you RIGHT handed or LEFT handed?* (Circle one)**

***If you are over age 65, have you had a pneumovax (pneumonia) vaccine?* Yes☐ No☐ When?**_____________

FAMILY HISTORY

RELATION	Alive/ Deceased	AGE	Has a problem similar to mine	All known health problems
MOTHER				
FATHER				
BROTHERS				
SISTERS				
CHILDREN				
OTHERS				

SYMPTOM REVIEW **Please check off the symptom(s) that you have RECENTLY experienced. If none, please check NONE.**

Constitutional	Eyes	Gastrointestinal	Endo/Heme/Allergies
Fever ☐	Blurred vision ☐	Heartburn ☐	Easy Bruising/Bleed ☐
Chills ☐	Double Vision ☐	Nausea ☐	Environmental allergies ☐
Weight Loss ☐	Light sensitivity ☐	Vomiting ☐	Excessive thirst ☐
Malaise/Fatigue ☐	Eye pain ☐	Abdominal pain ☐	**NONE** ☐
Excessive Sweating ☐	Eye discharge ☐	Diarrhea ☐	**Neurological**
Weakness ☐	Eye redness ☐	Constipation ☐	Dizziness ☐
NONE ☐	**NONE** ☐	Blood in stool ☐	Tingling ☐
Skin	**Cardiovascular**	Dark stool ☐	Tremor ☐
Rash ☐	Chest pain ☐	**NONE** ☐	Sensory Change ☐
Itching ☐	Palpitations ☐	**Genitourinary**	Speech Change ☐
NONE ☐	Shortness of breath ☐	Painful urination ☐	Focal weakness ☐
HEENT	Difficulty walking ☐	Urgency ☐	Seizures ☐
Headaches ☐	Leg swelling ☐	Frequency ☐	Loss of consciousness ☐
Hearing loss ☐	Night breathing trouble ☐	Blood in urine ☐	**NONE** ☐
Ringing in the ears ☐	**NONE** ☐	Flank pain ☐	**Psychiatric**
Ear pain ☐	**Respiratory**	**NONE** ☐	Depression ☐
Ear discharge ☐	Cough ☐	**Musculoskeletal**	Suicidal ideation ☐
Nosebleeds ☐	Blood in sputum ☐	Muscle pain ☐	Substance abuse ☐
Congestion ☐	Sputum production ☐	Neck pain ☐	Hallucinations ☐
High pitched wheezing ☐	Shortness of breath ☐	Back pain ☐	Nervousness/anxiety ☐
Sore throat ☐	Wheezing ☐	Joint pain ☐	Difficulty sleeping ☐
NONE ☐	**NONE** ☐	Falls ☐	Memory loss ☐
		NONE ☐	**NONE** ☐

Other things your doctor should know about you:

Patient signature:	**Reviewed by doctor:**
PLEASE INITIAL HERE IF ABOVE INFORMATION IS UNCHANGED FROM PRIOR VISIT: ☐	**Date:**