Center for Neurosciences

Rev. 04/05/2024 — MEDICAL CONSULTATION FORM —

NAME: _____ DATE: _____ CELL PHONE _____ (so we can call with results)

Email: _____ Age: _____ DOB: _____ Height: _____ Weight: _____

Gender identity: _____ Preferred pronouns: _____ (i.e. he/him; she/her) Pregnant? ❒ Yes ❒ No

Name of physician or person who sent you to see us _____ Name of primary care _____

Name(s) of any other physicians you would like our office note sent to: _____

Handedness: ❒ Right-handed ❒ Left-handed ❒ Ambidextrous

Work Status: ❒ Occupation _____ ❒ Current ❒ Previous ❒ Retired

❒ Disabled (reason) _____

What is the main reason for your visit today? _____

Please describe your symptoms: _____

_____

_____

Approximate date of onset of symptoms: _____

If this is a ***spinal problem***, please fill out the following:

Have you tried? Physical therapy ❒Yes ❒No

Steroid Injections ❒Yes ❒No

Do you have any of the following <u>diagnoses</u>?

Diabetes	❒ Yes	❒ No
Hypertension	❒ Yes	❒ No
Asthma or emphysema	❒ Yes	❒ No
Stroke	❒ Yes	❒ No
Heart disease	❒ Yes	❒ No
Heart attack	❒ Yes	❒ No
Bleeding disorder	❒ Yes	❒ No
Hepatitis	❒ Yes	❒ No
Cancer	❒ Yes	❒ No

Type of cancer: _____

Year of diagnosis: _____

Other diagnosis: _____

Review of Systems

❒ Weight loss	❒ Blood in the urine
❒ Fever or chills	❒ Easy bruising
❒ Skin rash	❒ Memory loss
❒ Decreased hearing	❒ Depression
❒ Double vision	❒ Nausea
❒ Shortness of breath	❒ Vomiting
❒ Heart palpitations	❒ Snore
❒ Loss of bowel control	❒ Trouble sleeping
❒ Loss of bladder control	❒ Sleepy during day

Influenza Vaccine: ❒ Yes ❒ No Date: _____

Pneumococcal Vaccine: ❒ Yes ❒ No Date: _____

Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Single

How many children do you have? _____

Do you smoke? ❒ Yes ❒ No Packs per day: _____ Did you previously smoke? ❒ Yes ❒ No Year you quit: _____

Do you drink alcohol? ❒ Yes ❒ No Amount: _____

Do you use street drugs? ❒ Yes ❒ No Type and Amount: _____

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MEDICAL CONSULTATION FORM

Do you have Advanced Directives/Living Will? ❒ Yes ❒ No

Please list all medications you currently take: ❒ None

It is acceptable to attach a list.

	Medication	Dosage	Frequency		Medication	Dosage	Frequency
1.				7.			
2.				8.			
3.				9.			
4.				10.			
5.				11.			
6.				12.			

Please list all allergies to medicines. ❒ None

	Allergy to:	Reaction:		Allergy to:	Reaction:
1.			3.		
2.			4.		

Please describe any major injuries you have had: ❒ None

1. _____ Date: _____
2. _____ Date: _____

Please describe surgeries you have had: ❒ None

1.	Date:		4.	Date:	
2.	Date:		5.	Date:	
3.	Date:		6.	Date:	

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No
If yes, describe: _____

Please list all **serious** illnesses your **blood relatives** have had.

Father: _____ Deceased at age: _____

Mother: _____ Deceased at age: _____

Brother(s): _____

Sister(s): _____

Children: _____

Test Scheduling and Result Follow Up Statement

During today's visit, you may have some tests ordered. We would like your help in insuring that the tests are scheduled and results are communicated to you in a timely fashion. Test authorization and test scheduling takes one to two weeks. Test results are generally returned within 1 week. If you do not hear from us within these time frames, please contact us.

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: _____ Date: _____