NEUROLOGY GROUP OF BERGEN COUNTY, P.A.

NAME ____________________________________**DATE** _______________
Occupation _________________________________ **Age** _________________

CHIEF COMPLAINT:

____
____
____
____

How long have the symptoms been present? _______________________________________
Is there anything that makes the symptoms worse? ____________________________________
better? __________________________________

NEUROLOGICAL SYMPTOMS:

Severe headache	Yes	/ No	Slurred speech	Yes	/ No
Fainting spells	Yes	/ No	Dizziness	Yes	/ No
Stroke/TIA	Yes	/ No	Numbness	Yes	/ No
Seizures	Yes	/ No	Blackouts	Yes	/ No
Severe head injury	Yes	/ No	Memory difficulty	Yes	/ No
Sudden visual loss	Yes	/ No	Depression	Yes	/ No
Double vision	Yes	/ No	Neck Pain	Yes	/ No
Hearing loss	Yes	/ No	Low back pain	Yes	/ No

Have you ever consulted a neurologist before: Yes / No
Are you right-handed or left-handed? RIGHT LEFT

PAST MEDICAL HISTORY:

High blood pressure	Yes	/ No	Diabetes	Yes	/ No
Heart disease	Yes	/ No	Depression	Yes	/ No
High cholesterol	Yes	/ No	Anxiety	Yes	/ No
Cancer	Yes	/ No	Ulcers	Yes	/ No
Type: ________________			Gastritis	Yes	/ No
Asthma	Yes	/ No	Kidney problems	Yes	/ No
Emphysema	Yes	/ No	Glaucoma	Yes	/ No
Thyroid disease	Yes	/ No	Hepatitis	Yes	/ No
Drug dependency	Yes	/ No	Sexually trans disease	Yes	/ No
Sleep Apnea	Yes	/ No	Blood transfusion	Yes	/ No
Lyme disease	Yes	/ No	HIV / AIDS	Yes	/ No

Other ______________________________________

SURGICAL HISTORY:

____
____
____

OTHER HOSPITALIZATIONS:

____
____
____

(PLEASE COMPLETE OTHER SIDE)

MEDICATIONS: (include dosage and frequency)

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________
9. ______________________________
10. ______________________________

ALLERGIES TO MEDICATIONS:

None Penicillin Sulfa drugs X-ray dye

Other: ______________________________

SOCIAL HISTORY:

Marital History: Single Married Divorced Separated Widowed

Smoking: Yes / No Amount ______________________________

When stopped? ______________________________

Alcohol: None Occasional Daily Amount? ______________

Living arrangements: Alone Spouse Children Parents Significant other

Where were you born?: ______________________________

Living Will? Yes / No Name of appointed agent: ______________________

FAMILY HISTORY: (check any that apply)

Migraine	Seizures	Brain Tumor	Cancer
Parkinson's	Alzheimer's	Stroke	type ____________
Nerve disease	Muscle diseases	Multiple Sclerosis	
Mental retardation	Depression	Mental illness	
Hypertension	Heart disease	Diabetes	

Father: Alive: Yes / No Cause of death (if deceased) ______________________

Mother: Alive: Yes / No Cause of death (if deceased) ______________________

Children: Yes / No # alive ________ # deceased ________ cause ______________

Siblings: Yes / No # alive ________ # deceased ________ cause ______________

REVIEW OF SYSTEMS: (circle any that apply)

CONSTITUTIONAL:	none	fever weight loss weight gain extreme fatigue fainting spells falls
SKIN:	none	rash skin cancer birthmarks (<5)
EYES:	none	pain in eyes wear glasses/contacts
ENT:	none	ringing in ears sinus infections grind teeth difficulty swallowing pain with swallowing
CARDIOVASCULAR:	none	chest pain palpitations irregular beat murmur
RESPIRATORY:	none	shortness of breath chronic cough wheezing
GASTROINTESTINAL:	none	nausea vomiting diarrhea constipation abd. pain
GENITO-URINARY:	none	incontinence urgency impotence
HEMATOLOGY:	none	bleeding tendency anemia easy bruising
GYNECOLOGY:	none	loss of menstrual period (excluding pregnancy)
PSYCHIATRIC:	none	depression anxiety hallucinations insomnia
MUSCULOSKELETAL:	none	muscle pain joint pain joint swelling stiffness

Patient's Signature ______________________________ **Reviewed by MD** ________

initials

(T/misc/forms/01/27/20)