

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
Prostate disorder	Yes / No	Blood transfusion	Yes / No
Lyme disease	Yes / No	HIV / AIDS	Yes / No
Other _____			

SURGICAL HISTORY:

OTHER HOSPITALIZATIONS:

(PLEASE COMPLETE OTHER SIDE)

