Capital Institute for Neurosciences

Date:_____

PATIENT NAME: _____ DOB: _____

DO YOU HAVE ANY ALLERGIES? _____

_____

PLEASE INDICATE DETAILED REASON(S) FOR THE VISIT:

1. _____

2. _____

3. _____

WERE YOU REFERRED? IF SO, BY WHOM: _____

HOW LONG HAVE YOU HAD THESE PROBLEMS? _____

HOW OFTEN DO THEY OCCUR? _____

WHAT OTHER DOCTORS HAVE YOU SEEN? _____

_____

WHAT MEDICATIONS DO YOU TAKE? _____

_____

_____

PLEASE CIRCLE ANY OF THE FOLLOWING SYMPTOMS YOU MAY HAVE:

HEAD, EARS, EYES, NOSE, THROAT
HEADACHES
HEARING LOSS
RINGING EARS
VISUAL CHANGES
SORE THROAT
NOSE BLEED
NONE OF THE ABOVE

MUSCULAR/SKELETAL
JOINT PAIN
LIMITED MOTION
BACK PAIN
MUSCLE ACHES & PAINS
MUSCLE WEAKNESS
NONE OF THE ABOVE

INTESTINES
NAUSEA, VOMITING
DIARRHEA
CONSTIPATION
ABDOMEN PAIN
WEIGHT CHANGE
APPETITE CHANGE
JAUNDICE
NONE OF THE ABOVE

URINARY
URINARY FREQUENCY
BLOOD IN URINE
LITTLE OR NO URINE
STONES
PUS IN URINE
INCONTINENCE
NONE OF THE ABOVE

CARDIAC/RESPIRATORY
CHEST PAIN
BLUE LIPS/NAIL BEDS
DIFFICULTY BREATHING
COUGH
SPUTUM
VARICOSE VEINS
SHORTNESS OF BREATH
NONE OF THE ABOVE

SKIN
RASH
ITCHING
SORES
EMPERATURE
FLUID RETENTION
NONE OF THE ABOVE

NEUROLOGICAL
HEADACHES
SPEECH DIFFICULTY
EQUILIBRIUM (BALANCE)
LOSS OF SLEEP
VISIONS
CONVULSIONS
TREMORS

DIZZINESS
SENSORY LOSS
DREAMS/NIGHTMARES
NUMBNESS
ANXIOUSNESS
NONE OF THE ABOVE

PATIENT NAME: _____ DOB: _____

HAVE YOU EVER BEEN SUSPECTED OF HAVING THE FOLLOWING (PLEASE CIRCLE)

	PATIENT	**FAMILY HISTORY**
DIABETES	YES/NO	YES/NO
HYPERTENSION	YES/NO	YES/NO
HEART DISEASE	YES/NO	YES/NO
ARTHRITIS	YES/NO	YES/NO
BLOOD CLOTS	YES/NO	YES/NO
KIDNEY PROBLEMS	YES/NO	YES/NO
STROKE	YES/NO	YES/NO
TUMOR	YES/NO	YES/NO
NEUROLOGICAL PROBLEMS	YES/NO	YES/NO

OTHER:

_____

_____

_____

PERSONAL

DO YOU:	SMOKE	YES/NO
	DRINK	YES/NO
	TAKE RECREATION DRUGS	YES/NO
	ARE YOU ON A SPECIAL DIET?	YES/NO

FAMILY HISTORY:

NUMBER OF CHILDREN:_____	LIVING	DECEASED	CAUSE OF DEATH _____
NUMBER OF BROTHERS:_____	LIVING	DECEASED	CAUSE OF DEATH _____
NUMBER OF SISTERS:_____	LIVING	DECEASED	CAUSE OF DEATH _____
MOTHER:	LIVING	DECEASED	CAUSE OF DEATH _____
FATHER:	LIVING	DECEASED	CAUSE OF DEATH _____

COMMENTS OR ADDITIONAL INFORMATION:

_____

_____

_____

_____

_____

_____

Physician Signature: _____