



Patient name \_\_\_\_\_  
 Age \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

Why were you referred to a neurologist? \_\_\_\_\_

Please list any medical conditions or major surgeries:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list the medications you currently take.

Name of medication	Number of mg.	How many times per day?

Are you allergic to any medications?    Yes                  No  
 If so, which ones? \_\_\_\_\_

Please circle answers to the following:

Smoking history:                  Current smoker    Former smoker                  Never smoked  
 Frequency of alcoholic beverages:                  Daily                  Weekly                  Rarely/never

Do your family members have any of the following conditions? Please circle.

Seizures or epilepsy                  Alzheimer's Disease                  Other \_\_\_\_\_  
 Huntington's Disease                  Parkinson's Disease  
 Cancer                  Heart attack  
 Stroke                  Migraine

Do you have any of the following symptoms? If so, please circle.

General	Weight loss	Weight gain	Fevers
Eyes	Blurry vision	Double vision	Loss of vision
Ear, Nose, Throat	Sinus infections	Ear pain/ fullness	Dizziness
Cardiovascular	Heart palpitations	Passing out	Poor circulation
Respiratory	Shortness of breath	Wheezing	Cough
Gastrointestinal	Burning in stomach	Constipation	Diarrhea
Genitourinary	Frequent urination	Impotence	Painful urination
Musculoskeletal	Weakness	Joint pain	Joint swelling
Skin	Rashes	Birthmarks	Skin growths
Psychiatric	Sadness/depression	Anxiety	Hallucinations