Neurological Associates of St. Paul Patient Information Sheet

Today's Date: _____

Name: _____ Date of birth: _____ Age: _____
Last First Middle Initial

Address: _____ Phone: _____ Home / Cell
Street Apt

_____ _____ Work
City State Zip

Marital Status: S M W D Spouse Name: _____

Occupation: _____

Name of doctor referring you here: _____

Family doctor if different from above: _____

Reason for visit: What symptoms are you having, and when did they start? _____

_____

_____

Have you missed any days of work due to this problem? YES ☐ NO ☐ Dates: _____

Are you currently on medical leave or disability? YES ☐ NO ☐ Last day worked: _____

Is this problem due to injury? YES ☐ NO ☐ Describe what happened: _____

_____

_____

Date of injury: _____ Did it happen at work? YES ☐ NO ☐ Auto accident? YES ☐ NO ☐

Have you been evaluated for this problem in the past? YES ☐ NO ☐

If so, when and where:_____

LIST CURRENT MEDICATIONS, including nonprescription drugs:

_____

_____

_____

_____

_____

_____

ALLERGIES:

_____

_____

_____

Do you smoke? YES ☐ NO ☐ How Much? _____

Have you ever smoked? YES ☐ NO ☐ For How Long?_____

Alcohol Use? YES ☐ NO ☐ How Much? _____

PHARMACY NAME & ADDRESS:

_____

_____

Pharmacy

Phone: _____ Fax: _____

HAVE YOU EVER HAD THE FOLLOWING TESTS / CONSTULTS? IF YES—WHERE AND WHEN:

CT _____
MRI _____
Cerebral Angiogram _____
EMG _____
EEG _____
Myelogram _____
Holter EKG (24hr) _____
Spinal Tap _____
Previous Neurological Consultation _____

CONTINUED ON BACK 

REVIEW OF SYSTEMS

Please answer each line YES or NO:

YES	NO		YES	NO	
☐	☐	Neck Pain	☐	☐	Sleeping Problems
☐	☐	Back Pain	☐	☐	Headaches
☐	☐	Arm / Leg Pain	☐	☐	Seizures
☐	☐	Joint Pain	☐	☐	Blackout Spells
☐	☐	Numbness / Tingling	☐	☐	Memory Loss
☐	☐	Weakness / Paralysis	☐	☐	Anxiety
☐	☐	Difficulty Walking	☐	☐	Depression
☐	☐	Falling	☐	☐	Chest Pain
☐	☐	Balance / Coordination Problems	☐	☐	Palpitations
☐	☐	Movement Disorder or Tremor	☐	☐	Cardiac / Heart Problems
☐	☐	Bladder Symptoms	☐	☐	Bloating
☐	☐	Impotence	☐	☐	Stomach Pain / Distress
☐	☐	Dizziness	☐	☐	Bowel Problems
☐	☐	Speech Disturbance	☐	☐	Respiratory Problems
☐	☐	Difficulty Swallowing	☐	☐	Skin Changes / Rash
☐	☐	Ringing in Ears	☐	☐	Weight Gain or Loss
☐	☐	Hearing Loss	☐	☐	Appetite Problems
☐	☐	Visual Symptoms	☐	☐	Snore Loudly
☐	☐	Sleepy During the Day	☐	☐	Stop Breathing During Sleep

SELF

Have you ever been diagnosed:

PLEASE CHECK		
	YES	NO
Stroke	☐	☐
Heart Attack	☐	☐
High Cholesterol	☐	☐
High Blood Pressure	☐	☐
Diabetes	☐	☐
Epilepsy or Seizures	☐	☐
Migraine or Severe Headache	☐	☐
Bleeding Tendency	☐	☐
Tremor or Movement Disorder	☐	☐
Parkinsons Disease	☐	☐
Multiple Sclerosis	☐	☐
Mental Illness	☐	☐
Memory Loss / Alzheimer's	☐	☐
Arthritis	☐	☐
Visual Loss	☐	☐
Nervous Breakdown	☐	☐
Suicide or Attempt	☐	☐
Depression	☐	☐
Osteoporosis (Brittle Bones)	☐	☐
Cancer / Leukemia	☐	☐
Sleep Disorder	☐	☐

FAMILY HISTORY

Any blood relatives have history of:

PLEASE CHECK			
	YES	NO	WHICH RELATIVE?
Stroke	☐	☐	
Heart Attack	☐	☐	
High Cholesterol	☐	☐	
High Blood Pressure	☐	☐	
Diabetes	☐	☐	
Epilepsy or Seizures	☐	☐	
Migraine or Severe Headache	☐	☐	
Bleeding Tendency	☐	☐	
Tremor or Movement Disorder	☐	☐	
Parkinsons Disease	☐	☐	
Multiple Sclerosis	☐	☐	
Mental Illness	☐	☐	
Memory Loss / Alzheimer's	☐	☐	
Arthritis	☐	☐	
Visual Loss	☐	☐	
Nervous Breakdown	☐	☐	
Suicide or Attempt	☐	☐	
Depression	☐	☐	
Osteoporosis (Brittle Bones)	☐	☐	
Cancer / Leukemia	☐	☐	
Sleep Disorder	☐	☐	

RELATIVE AGE AT DEATH & CAUSE:

Father_____

Mother _____

Sister (s)_____

Brother (s) _____

Children _____