ALL NEUROLOGICAL SERVICES, P.C.

Name: _____ Age: ___ Gender: ___ Date of Appointment: _____

Primary Care Physician Name:

_____

Reason for Visit

What brings you to the office today?

_____

_____

Date symptoms started _____

Medications

What medications are you currently taking? (Include aspirin, other blood thinners)

Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency
Name	Dosage	Frequency

Family History

Has anyone in your family ever had any of the following conditions?

- ☐Alzheimer's/Dementia
- ☐Aneurysm
- ☐Blood Clots
- ☐Brain Tumor
- ☐Diabetes
- ☐Heart Attack
- ☐High Blood Pressure
- ☐Migraines
- ☐Muscle Disease
- ☐Neuropathy
- ☐Parkinson's Disease
- ☐Seizures
- ☐Stroke
- _____

Allergies

Are you allergic to any of the following?

- ☐NSAID's(Ibuprofen, Tylenol, Naproxyn)
- ☐Adhesive Tape
- ☐Anesthetics
- ☐Codeine
- ☐Latex
- ☐Iodine(including contrast dye)
- ☐Penicillin
- ☐Seizure Medicines
- ☐Sulfa
- ☐Other _____

Allergic Reactions: _____

Past Medical History

Have you ever had any of the following?

- ☐AIDS / HIV
- ☐Alcoholism
- ☐Anemia
- ☐Aneurysm
- ☐Anxiety Disorder
- ☐Asthma
- ☐Atrial Fibrillation
- ☐Bleeding Disorder
- ☐Blood Clot
- ☐Cancer, Type _____
- ☐Carotid Artery Surgery
- ☐Cataracts
- ☐Chronic Fatigue
- ☐Chronic Pain Where? _____
- ☐COPD
- ☐Depression
- ☐Fibromyalgia
- ☐Glaucoma
- ☐Head Injury
- ☐Heart Disease
- ☐Hepatitis B or C
- ☐Herpes
- ☐High Cholesterol
- ☐Kidney Disorder
- ☐Liver Disease
- ☐Lupus
- ☐Migraines
- ☐Osteoporosis
- ☐Pacemaker
- ☐Skin Disorder
- ☐Sleep Apnea
- ☐Stroke
- ☐Substance Abuse
- ☐Tuberculosis
- ☐High Blood Pressure
- ☐Diabetes
- Other: _____

Are you (check one):

☐Right Handed ☐Left Handed ☐Ambidextrous

Women Only

Number of Pregnancies: _____

Number of Miscarriages: _____

Number of Abortions: _____

Number of Living Children: _____

Birth Control: ☐Yes ☐No If Yes, type _____

Date of Last Period: _____

Hospitalizations & Surgeries

Reason	Year
Reason	Year
Reason	Year

Patient Signature: _____

Doctor Signature: _____