PHOENICIAN NEUROLOGICAL INSTITUTE

New Patient Intake Form

Patient Name: ______________________________ Date of Birth: _________ Age: ___ Sex: ___ Date: ______________

Referred by: ______________________ Doctors/Neurologists seen for this complaint: ___________________________

Current Complaint / Reason for Visit:

1. ____Since: ____________
2. ____Since: ____________
3. ____Since:_____________
4. ____Since:_____________

Current Medications (List all medications including nonprescription/over the counter that you currently take

Name of Medication	Mg	Times a day	Prescribed by
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Drug Allergies / Reaction: ____

Alcoholism	Chills	Glaucoma	Kidney Disease	Neuropathy	Stroke
Allergy	Chronic fatigue	Gout	Kidney Stone	Overactive Bladder	Suicide Attempt
Anemia	Chronic Pain	Heart Attack	Learning Disability	Pacemaker/Stent	Syphilis
Arthritis	Colon Problems	Heart Disease	Liver Disease	Parkinson’s	Thyroid disease
Arrhythmia	Concussion	Hepatitis	Loss of Appetite	Peptic Ulcer	TIA
Asthma	COPD	Herpes Zoster	Lung Disease	Psychiatric treatment	TMJ
Atrial Fibrillation	Depression/Anxiety	High Blood Pressure	Lupus	Psychological Disorder	Tremor
Back Pain	Diabetes	High Cholesterol	Meningitis	Rheumatic Fever	Tuberculosis
Bladder Problems	Drug Use	HIV	Mental Disease	Sexual Problems	Vertigo
Bleeding/Clotting	Emphysema	Possible HIV contact	Migraine	Seizures (spells)	Ulcers/Colitis
Blood Disorders	Encephalitis	Hyperlipidemia	Multiple Sclerosis	Sinus Disease	Weight loss/gain
Blood transfusion	Fevers	Immune Disorder	Narcolepsy	Sleep Disturbance	

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Cancer of _______	Fibromyalgia	Irritable Bowel	Neck Pain	Spinal Cord Injury	

Recent accidents or injuries:

____

Patient Name: ____ Date: ______________

Neurological History: (Circle all that apply)

Balance Problems	Double Vision	Headache	Numbness	Swallowing Problem	Weakness
Bowel/Bladder	Facial Numbness	Hearing Loss	Personality Change	Tingling	Prior Neurology Consult
Confusion	Facial Pain	Involuntary movement	Ringing in ears	Visual Loss	Psychiatry consult
Coordination	Fainting	Low back pain	Smell/Taste	Vitamin Deficiency	Psychology consult
Dizziness	Head Injury	Memory Loss	Speaking problem	Walking problem	

List All Prior Hospitalizations:

Name of Hospital	Year	Reason for Hospitalization	Name of Hospital	Year	Reason for Hospitalization

Surgical History: (List All Prior Surgical Procedures)

Procedure	When & Where Performed	Procedure	When & Where Performed

Prior Radiographic/Diagnostic Tests (Check Normal or Abnormal, name of ordering Doctor & location performed)

Test Name	Date Performed	Normal (check box)	Abnormal (check box)	Ordered By	When & Where
Carotid Doppler					
CT Scan of					
EMG/NCV					
Lumbar Puncture					
MRI of					
Myelogram/CT					
Sleep Study					
X-ray of					
EEG (brain wave)					

Blood Tests					

Personal/Social History

Marital Status: (Circle) Married Widowed Divorced Separated Single Number of Children: ___________ Ages: _________________________

Occupation: ____ Education: (Circle) Grade School High School College College graduate

Habits: Do you smoke? Yes No How many years? _____ How many per day? ____ Quit when? ________________

Do you ever drink alcohol? Yes No How many per week? _______ Do you use recreational Drugs? Yes No If yes, which ones? ______________

Caffine intake? Yes No (How many per day?) Coffee ____ Tea ____ Sodas ____

Family History	Alive	Deceased	Age	Medical Problem
Father				
Mother				
Sister(s)				
Brother(s)				