Penn Medicine

Neurology

New Patient Neurology Intake Form

First Name:	**Last Name:**
Date of Birth:	**Primary Care Provider:**
Appointment Date:	**Appointment Time:**

Have you had any of the following symptoms RECENTLY (over the past month)?

YES	NO		YES	NO		YES	NO	
		Headaches			Chest Pain			Weight Loss
		Eye Pain			Anxiety			Weight Gain
		Blurred Vision			Depression			Frequent Fevers
		Double Vision			Skin Rash			Sinus Congestion
		Hearing Loss			Tremor			Frequent Infections
		Ringing in the Ears			Vomiting			Arm Pain
		Dizziness/Lightheaded			Nausea			Arm Weakness
		Difficulty Swallowing			Stomach Pain			Arm Numbness
		Difficulty Speaking			Stool Incontinence			Arm Tingling
		Facial Weakness			Diarrhea			Leg Pain
		Facial Numbness			Constipation			Leg Weakness
		Back Pain			Blood in Stool			Leg Numbness
		Neck Pain			Trouble Urinating			Leg Tingling
		Racing Heart Rate			Nocturnal Urination			Joint Pain
		Frequent Cough			Painful Urination			
		Shortness of Breath			Impotence			

Please provide details about any of the symptoms above that are currently bothering you: _____

_____

Are there any other symptoms that are bothering you that were not listed above?

_____

_____

_____

_____

Patient Signature: _____ **Date:** _____

Have you had any neurological studies performed (MRI, CT, EEG, EMG)?

If so, when? _____ Where?

_____

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New Patient Intake Form Continued...

Have you had any of the following conditions?

YES	NO		YES	NO		YES	NO	
_____	_____	Stroke/TIA	_____	_____	Diabetes	_____	_____	High Cholesterol
_____	_____	Seizures	_____	_____	Thyroid illness	_____	_____	Stomach Ulcers
_____	_____	Heart Attack	_____	_____	Kidney illness	_____	_____	Abnormal Bleeding
_____	_____	High Blood Pressure	_____	_____	Liver illness	_____	_____	Abnormal Clotting
_____	_____	Pacemaker	_____	_____	Cancer			

Other medical conditions *(please list):* _____

_____

Recent hospitalizations *(in past year):* _____

_____

Previous major operations *(within the last 10 years):* _____

_____

Medication Allergies: _____

Family history of neurological or other disorders: _____

_____

Current Medication List	Strength (mg)	Directions

Social History:

YES	NO			
_____	_____	**Do you smoke tobacco?**	_____ **= packs per day**	**Date quit:** _____
_____	_____	**Do you drink alcohol?**	_____ **= drinks per week**	
_____	_____	**Are you married?**	_____ **= total years married**	
_____	_____	**Do you have any children?**	_____ **= total children**	
_____	_____	**Are you currently employed?**	**If so, what line of work?** _____	

Physician's signature: _____ **Date:** _____