ADC Neurology New Patient Examination Questionnaire for Dr. Reading

Name: _____ **Date of Birth:** _____
Reason for visit: _____
Referring doctor or primary care: _____
Who is with you today? _____
Occupation: _____ **Handedness:** ☐ Right ☐ Left ☐ Ambidextrous

Review of Systems:

General:	☐ Fever	☐ Chills	☐ Sweats	☐ Fatigue
Eyes:	☐ Blurred	☐ Double	☐ Eye pain	☐ Vision loss
ENT:	☐ Hearing loss	☐ Ringing in ears	☐ Trouble swallowing	
Cardio:	☐ Chest pain	☐ Palpitations	☐ Dizziness/light headed	
Respiratory:	☐ Cough	☐ Wheezing	☐ Shortness of breath	
GI:	☐ Nausea	☐ Vomiting	☐ Diarrhea	☐ Constipation
GU:	☐ Incontinence	☐ Frequency	☐ Blood in urine	
Musculoskeletal:	☐ Back pain	☐ Joint pain	☐ Muscle weakness	☐ Muscle soreness
	☐ Swelling	☐ Cramping	☐ Stiffness	
Skin:	☐ Rash	☐ Itching	☐ Dryness	
Neurologic:	☐ Weakness	☐ Numbness/tingling	☐ Seizure	☐ Passed out/fainted
	☐ Tremors	☐ Headaches/Migraines		
Psychologic:	☐ Depression	☐ Anxiety	☐ Memory	☐ Suicidal Ideation
Endo:	☐ Cold intolerance	☐ Heat intolerance	Weight change >10 lbs in last month: ☐ gain ☐ loss	
Lymph/Hema:	☐ Abnormal bruising	☐ Bleeding		
Allergy:	☐ Hay fever	☐ Persistent infection(s)		

Other Symptoms not listed: _____
_____

What medical problems do you have or have had:

☐ AIDS	☐ Diabetes	☐ Osteoporosis	Other Medical Problems not listed:
☐ Asthma	☐ Emphysema	☐ Thyroid Hyper / Hypo	_____
☐ Blood Pressure	☐ Heart Attack	☐ Prostate problems	_____
☐ Cancer: type_____	☐ Kidney Stones	☐ Rheumatoid Arthritis	_____
☐ CHF	☐ Liver Problems	☐ Seizure	_____
☐ Cholesterol	☐ Lupus	☐ Stroke	_____
☐ Depression	☐ Migraines	☐ Ulcers type: _____	_____

Any Surgeries: _____
_____

Social History: How many alcoholic beverage(s), on average do you consume? _____

Do you Smoke? ☐ Never ☐ Former Current: ☐ Daily ☐ Sometimes ☐ Light tobacco ☐ Heavy tobacco

Type: ☐ Cigarettes ☐ e-Cigarettes ☐ Cigars ☐ Pipe ☐ Chewing Tobacco

per day: _____ Years used: _____ Date quit: _____

Do you live: ☐ Alone ☐ Married ☐ w/Children ☐ Significant Other ☐ Assisted Living ☐ Roommates

Do you drink caffeine? ☐ Tea ☐ Coffee ☐ Soda ☐ Decaf

Family History:

Mother	Living_____	Deceased _____	Medical Issues _____
Father	Living_____	Deceased _____	Medical Issues _____
Siblings	Living_____	Deceased _____	Medical Issues _____
Children	Living_____	Deceased _____	Medical Issues _____

Please bring a list of medications you are taking, including prescription and non-prescription medications (such as vitamins, supplements, herbs, over-the-counter meds like Advil, etc.).