GREATER MILFORD NEUROLOGY'S REGISTRATION FORM

Today's Date: _____ Is this a Workers Comp _____ or a Motor Vehicle Accident_____

PATIENT INFORMATION

FIRST NAME: _____ LAST NAME: _____

Date of birth: _____ Age: _____ Sex: (CIRCLE) → **M or F**

Primary Care Provider: _____ Referred by: _____

***** REASON FOR TODAY'S VISIT:***

_____

PERSONAL QUESTIONANAIRE:

Height: _____ Weight: _____ Are you Right or Left Handed? (CIRCLE) → **L or R**

Marital Status: Single ---- Married ---- Partnered ---- Separated ---- Divorced ---- Widowed

Occupation: Employed—Homemaker—Retired—Disabled—Unemployed → If employed, what is your occupation and are you Full-time or Part-time? _____

# of children: _____ Who do you live with at home? _____

Do you feel safe where you are currently living? (CIRCLE) → Yes or No

Do you exercise? If yes, what type of exercise and how often?

_____

When was your most recent flu vaccine? _____

When did you receive your Pneumonia vaccine? _____

HEALTH HABITS:

Alcohol:

Do you drink alcohol? (CIRCLE) → Yes or No
If yes, how many per day, week, or month? _____
Have you ever had a problem with alcohol? (CIRCLE) → Yes or No

Smoking:

Do you use tobacco? (CIRCLE) → Yes or No
If yes, what year did you start smoking? _____and how much do you smoke per day? _____
If a former smoker, what year did you stop smoking? _____
If you've never used tobacco, please check here _____

Do you smoke Marijuana? (CIRCLE) → Yes or No
If yes, how much and how often? _____

Do you or have you used illicit drugs in the past? (CIRCLE) → Yes or No

YOUR MEDICAL HISTORY:

~ If you have any of the following medical issues please check all that apply:

- o High Blood Pressure
- o Heart Condition
- o Heart Attack
- o High Cholesterol
- o Circulation Problems
- o Lung Problems
- o Kidney Disease
- o Bladder Problems
- o Liver Disease
- o Stomach Conditions
- o Bowel Problems
- o Arthritis
- o Chronic Back Pain
- o Osteoporosis
- o Migraine/Headaches
- o Seizure Disorder
- o Epilepsy
- o Stroke
- o Anxiety Disorder
- o Depression
- o Bipolar Disorder
- o Psychiatric Hospitalization
- o Diabetes
- o Thyroid
- o Fibromyalgia
- o Optic Neuritis
- o Glaucoma
- o Macular Degeneration
- o Dementia
- o Alzheimer's Disease
- o Cancer:_____ _____
- o OTHER:_____ _____

SURGICAL HISTORY:

~Please list all surgical procedures:

Type of surgery: ***Year:***

- o _____
- o _____
- o _____
- o _____
- o _____
- o _____
- o _____

--Have you ever had a blood transfusion? (CIRCLE) → Yes or No

HOSPITALIZATIONS:

~Please list all neurologic hospitalizations:

Reason for hospitalization: ***Year:***

- o _____
- o _____
- o _____
- o _____

REVIEW OF SYSTEMS:

~Are you having any of the following problems?

If yes, please circle all that apply:

- **GENERAL:** Weight loss, weight gain, fatigue, fever, chills, insomnia, loss of appetite.
- **SKIN:** Rashes, lumps, color changes, ulcers.
- **EYES:** Vision loss, blurry vision, double vision, eye pain, redness, flashing lights, drooping lid.
- **EAR/NOSE/THROAT:** Hearing loss, ringing in ears, nosebleeds, sinus pain, throat pain, hoarseness, trouble swallowing, dry mouth.
- **CARDIOVASCULAR:** Chest pain, palpitations, dizziness, fainting, irregular heartbeat, swollen feet.
- **RESPIRATORY:** Shortness of breath, wheezing, coughing.
- **GASTROINTESTINAL:** Nausea, vomiting, heartburn, constipation, diarrhea, blood in stool.
- **GENITOURINARY:** Frequency/urgency with urination, burning/pain with urination, urinary incontinence, frequent urination during the night, erectile dysfunction, pain during sex.
- **MUSCULOSKELETAL:** Joint pain, joint swelling, stiffness, muscle cramps, muscle spasms, neck pain, back pain.
- **PSYCHIATRIC:** Anxiety, depression, panic and mood disorder.
- **ENDOCRINE:** Heat intolerance, cold intolerance, sweating, increased thirst, change in appetite, hormonal issues.
- **HEMATOLOGIC:** Anemia, blood clots, low blood count, bruise easily, bleed easily, enlarged lymph nodes.
- **NEUROLOGIC:** Light headedness, vertigo, numbness or tingling, weakness, headaches, seizures, difficulty with balance, loss of consciousness, memory loss, difficulty walking.
- **IMMUNOLOGIC:** Itchy eyes, watery eyes, hives, runny nose, stuffy nose, recurrent infection.
- **SLEEP:** Daytime sleepiness, difficulty falling asleep, snoring, difficulty staying asleep, restless legs, sleep walking, vivid dreams.

FAMILY HEALTH HISTORY:

~Please check off any and all medical illness that apply to any of your family members and list the relationship and what side of the family they are on.

~***Blood related relatives ONLY. Living or Deceased. Not including yourself.*** → *Please include the following people: Parents, Siblings, Aunts, Uncles, Grandparents, Children.*

~Check here if you are adopted→ ___ Check here if family health history is unknown→ ___

	YES	**NO**	WHO IN YOUR **IMMEDIATE** FAMILY HAD THIS ILLNESS?	**MATERNAL** OR **PATERNAL**?
MULTIPLE SCLEROSIS				
HEADACHES/MIGRAINES				
MUSCLE DISEASE				
SEIZURES/EPILEPSY				
TREMOR/SHAKING				
PARKINSON'S DISEASE				
CEREBRAL ANEURYSM				
HEART DISEASE				
HEART ATTACK				
ASTHMA				
KIDNEY FAILURE				
BLEEDING DISORDERS				
DIABETES				
LUNG CANCER				
STROKE				
BRAIN TUMOR				
ALZHEIMER'S				
DEMENTIA				
COLON CANCER				
BREAST CANCER				
PROSTATE CANCER				
OVARIAN CANCER				
HIGH BLOOD PRESSURE				
PSYCHIATRIC DISORDER				
DEPRESSION				
PLEASE LIST ANY OTHER TYPES OF ILLNESS OR CANCERS THAT WERE NOT ON THIS LIST BUT ARE IN YOUR FAMILY:				

MEDICATION & ALLERGY LIST:

~ Do you have any medication allergies? (CIRCLE) → Yes or No

If yes, please list them here: _____

_____

_____

~ Are you currently taking any prescribed or over the counter medications?

If yes, please list them here:

Name of the Drug:	**Strength of the Drug:**	**# of tablets or capsules taken:**	**Frequency & Times Taken:**