NORTH SHORE NEUROLOGY & EMG, LLC - NEW PATIENT INTAKE/ROS FORM

Today's Date:		**Gender:**	Male / Female
Name:		**Height:**	**Weight:**
Birthdate:	_____/_____/_____ (mm/dd/yyyy)	**Referred by:**	
Age:		**Primary Care Physician:**	
Are you right or left handed? Left / Right		**Previous neurologists:**	
WHAT IS THE REASON FOR YOUR VISIT TODAY? ----------		**IS THIS RELATED TO WORKER'S COMP, MVA OR A THIRD PARTY LIABILITY CLAIM?** (If yes, see Financial Responsibility Agreement) ☐ Yes ☐ No	

PAST MEDICAL HISTORY: Please list **prior and current medical history**, even if your medications have fixed the problem (i.e. high blood pressure, high cholesterol, heart attack, depression, stroke, seizure etc.)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

PAST SURGICAL HISTORY: Please list prior surgeries with approximate dates (i.e. appendectomy, gall bladder removal, tonsillectomy, orthopedic, brain surgery, cardiac bypass etc.)

OPERATION	REASON / YEAR
1.	
2.	
3.	
4.	
5.	

Do you have ALLERGIES to medication, food, latex, adhesives? ☐ Yes ☐ No
If yes, please explain:

Please list **CURRENT MEDICATIONS** with dosage (including aspirin, Advil, vitamins)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

SOCIAL HISTORY	Do you smoke currently? ☐ Yes ☐ No
Marital Status:_____	If you quit, what year? _____
Circle: Heterosexual, homosexual, transgender?	Prior to quitting, # packs per day? _____
Occupation:_____	How many years did you smoke? _____
Number and ages of children:_____	Recreational drug use? ☐ No ☐ If Yes, what? _____
Do you drink alcohol? ☐ No ☐ If Yes, how many/day? __	Physical, emotional, sexual abuse? _____

FAMILY HISTORY: List all serious family medical illnesses, cancers, dementia, migraine, stroke, epilepsy, nerve/muscle diseases (father, mother, siblings, your children)

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Have you been on any **neurologic medications** in the past to treat the problem related to your visit today such as aspirin, Plavix, Coumadin, blood thinners, anti-seizure medicines, or medications for headaches, depression, anxiety, memory loss, pain? If **yes**, please provide details:

If you are having ***pain related to your visit today***, please rate it by circling on scale below:
0 (no pain) 1 2 3 4 5 6 7 8 9 10 (worst pain of your life)
How would you describe yourpain? _____
What makes it worse? _____ What makes it better? _____

REVIEW OF SYSTEMS

Have you had any of the following in the last 12 months?

CONSTITUTIONAL		
Fever	□ Yes	□ No
Chills	□ Yes	□ No
Fatigue	□ Yes	□ No
Loss of appetite	□ Yes	□ No
Unexpected weight loss	□ Yes	□ No
EYES/ EARS / NOSE / THROAT		
Blurred or double vision	□ Yes	□ No
Eye pain	□ Yes	□ No
Ear infection	□ Yes	□ No
Sore throat	□ Yes	□ No
Sinus problems	□ Yes	□ No
Difficulty swallowing	□ Yes	□ No
CARDIOVASCULAR		
Chest pain or angina	□ Yes	□ No
Palpitations / irregular beat	□ Yes	□ No
Heart murmur	□ Yes	□ No
Ankle or foot swelling	□ Yes	□ No
Leg pain with walking	□ Yes	□ No
Heart attack	□ Yes	□ No
Fainting	□ Yes	□ No
PULMONARY		
Shortness of breath	□ Yes	□ No
Wheezing	□ Yes	□ No
Frequent cough	□ Yes	□ No
Coughing blood	□ Yes	□ No
HEMATOLOGICAL		
Anemia	□ Yes	□ No
Easy bruising	□ Yes	□ No
Easy bleeding	□ Yes	□ No
SKIN		
Persistent itch	□ Yes	□ No
New Lesion / Rash	□ Yes	□ No
PSYCHOLOGICAL		
Generally happy with life?	□ Yes	□ No
Severe depression	□ Yes	□ No
Considered suicide	□ Yes	□ No
Anxiety	□ Yes	□ No
Difficulty sleeping	□ Yes	□ No

GASTROINTESTINAL		
Heartburn / acid reflux	□ Yes	□ No
Abdominal pain	□ Yes	□ No
Nausea and/or vomiting	□ Yes	□ No
Diarrhea	□ Yes	□ No
Constipation	□ Yes	□ No
Blood in stool	□ Yes	□ No
ENDOCRINE		
Excessive thirst	□ Yes	□ No
Too hot or too cold	□ Yes	□ No
Blood sugar problems	□ Yes	□ No
Irregular menstrual cycles	□ Yes	□ No
MUSCULOSKELETAL		
Joint pain	□ Yes	□ No
Neck pain	□ Yes	□ No
Back pain	□ Yes	□ No
NEUROLOGICAL		
Numbness or tingling	□ Yes	□ No
Arm / Leg weakness	□ Yes	□ No
Tremors	□ Yes	□ No
Seizures	□ Yes	□ No
Memory loss	□ Yes	□ No
Vertigo	□ Yes	□ No
Frequent headaches	□ Yes	□ No
GENITOURINARY		
Frequent urination	□ Yes	□ No
Urinary incontinence	□ Yes	□ No
Urinary retention	□ Yes	□ No
LYMPHATIC		
Swollen glands	□ Yes	□ No
Swelling of arms / legs	□ Yes	□ No
ALLERGY / IMMUNOLOGY		
Hay fever	□ Yes	□ No
Frequent infections	□ Yes	□ No

OTHER

Anything else you would like to add or discuss today?

_____