NEUROLOGICAL CONSULTATION NOTE:

Patient:_____ **Referring MD:**_____ **Date:** _____

Age: _____ **Height:** _____ **Weight:** _____ **Circle One:** Right-handed / Left-handed

Chief Complaint (Reason For Visit): _____
_____
_____
_____

IS THE REASON FOR YOUR VISIT THE RESULT OF A WORK OR MOTOR VEHICLE ACCIDENT? YES___ NO___

PAST MEDICAL HISTORY *(Please check all that apply: if not applicable leave blank)*

O Cataracts
O Glaucoma
O Thyroid Disease
O Angina
O Heart Attack: Year: _____
O High Cholesterol
O Congestive Heart Failure
O Rheumatic Fever
O Atrial Fibrillation
O Loss of Consciousness
O High Blood Pressure

O Asthma
O Ulcers: O Stomach O Intestinal O Acid Reflux
O Diabetes
O Head Injury: Year: _____
O Anemia
O Hepatitis
O Cancer: Type/Year Diagnosed: _____
_____
O Arthritis
O Tuberculosis
O Seizures
HIV STATUS: Positive / Negative / Unknown

O Other: _____
_____

O Past Surgeries: _____
_____

PRESENT MEDICATIONS

Medication Name	Dosage (# Milligrams)	How Many Times Taken Daily
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

Check Box ☐ if all below are negative.

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
High Blood Pressure	O	O	O	O	O	O
Heart Disease	O	O	O	O	O	O
Diabetes	O	O	O	O	O	O
Epilepsy	O	O	O	O	O	O
Stroke	O	O	O	O	O	O
Migraine Headaches	O	O	O	O	O	O
Dementia	O	O	O	O	O	O

SOCIAL HISTORY

Alcohol: ☐ None ☐Occasional social drinker ☐Small to moderate daily drinker ☐ Alcoholic

Have you ever been a smoker? ☐ Yes ☐ No

Are you still a smoker? ☐ Yes ☐ No If yes, how many packs per day: _____

Addictive (non-prescribed) Drug Use: ☐None ☐Yes: Please list drugs: _____

WORK HISTORY

JOB TITLE/DESCRIPTION: _____ ☐ Desk Job ☐ Physical Job

REVIEW OF SYSTEMS

Please check all that are CURRENT symptoms: if not a current symptom, leave blank.

Check Box ☐ if all below in **Review Of Systems** are negative.

Constitutional/ Other:
- O Awaken with or develop daytime numbness and/or tingling in hands
- O Numbness and/or tingling in feet
- O Fatigue
- O Weight Loss
- O Fevers
- O Headaches

Eyes:
- O Blurred Vision
- O Double Vision
- O Other: _____

Ear/Nose/Throat:
- O Hearing Loss
- O Vertigo
- O Ringing/Buzzing In Ears
- O Other: _____

Cardiovascular:
- O Shortness Of Breath on Exertion
- O Shortness Of Breath When Lying Flat
- O Chest Pain
- O Palpitations
- O Other: _____

Skin:
- O Rashes
- O Itchy Skin
- O Other: _____

Respiratory:
- O Shortness of Breath
- O Wheezing
- O Cough
- O Other: _____

Hematology:
- O Easy Bruisability
- O Blood Clotting Deficiency
- O Other: _____

Gastrointestinal:
- O Nausea/Vomiting
- O Heartburn
- O Abdominal Pain
- O Diarrhea
- O Constipation
- O Other:_____

Genitourinary:
- O Urinary Frequency or Urgency
- O Urinary Incontinence
- O Painful Urination
- O Impotence
- O Other: _____

Psychiatric:
- O Depression
- O Hallucinations
- O Psychiatric Hospitalizations: Year: _____
- O Other: _____

Allergies: To Medications: None ☐ (or list them) _____

To shellfish/ iodine: ☐No ☐Yes