NAME:_____ Birthdate___/___/___ Age_____

Reason for Neurological Evaluation: _____

Are You: ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

MEDICATIONS: Please list current medications including prescription and non-prescription (over the counter) drugs, vitamins, supplements, etc. Include the milligram dosage and how often you take them.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST:

- ☐ TIA
- ☐ Stroke
- ☐ Seizures
- ☐ Epilepsy
- ☐ Migraine
- ☐ Dementia
- ☐ Alzheimer's Disease
- ☐ Parkinson's Disease
- ☐ Multiple Sclerosis
- ☐ Brain Tumor
- ☐ Spinal Tumor
- ☐ Meningitis
- ☐ Encephalitis
- ☐ Concussion
- ☐ Brain Injury
- ☐ Spine Injury
- ☐ High Blood Pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Heart Attack
- ☐ Atrial Fibrillation
- ☐ Heart Failure
- ☐ Heart Valve Disease
- ☐ Fainting
- ☐ Pacemaker/Defibrillator
- ☐ Asthma
- ☐ Emphysema
- ☐ Stomach Ulcers/GERD
- ☐ Liver Disease
- ☐ Pregnancies/deliveries
- ☐ Syphilis
- ☐ Miscarriage
- ☐ Kidney Disease
- ☐ Kidney Stones
- ☐ Thyroid Disease
- ☐ Lupus
- ☐ Arthritis
- ☐ Lyme Disease
- ☐ Cancer
  Type _____
- ☐ Glaucoma
- ☐ Anxiety
- ☐ Depression
- ☐ Psychosis
- ☐ Alcoholism
- ☐ Drug Abuse
- ☐ AIDS/HIV
- ☐ Tuberculosis
- ☐ Sleep Apnea

PLEASE LIST ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE:

_____

_____

_____

_____

ALLERGIES: Please list all medications that have caused you to have an allergic reaction or other serious side-effect. List name of drug and brief description of reaction.

_____ _____

_____ _____

_____ _____

_____ _____

PLEASE LIST ANY SURGERY YOU HAVE HAD:

_____

_____

_____

NAME:_____ Birthdate___/___/___ Age_____

FAMILY HISTORY:

1. Do any blood relatives have a problem/diagnosis similar to your current problem?
   ☐ Yes ☐ No

2. Have any of your blood relatives ever had any of the following?
   ☐ Stroke ☐ Epilepsy ☐ Migraine ☐ Alzheimer's disease
   ☐ Parkinson's disease ☐ Multiple Sclerosis ☐ Neuropathy

3. List any other medical conditions that your parents, siblings or children have or have had:

_____ _____

_____ _____

SOCIAL HISTORY:

SMOKING: ☐ Never smoked ☐ Quit Smoking: When did you quit?_____
☐ Currently smoking How much?_____

ALCOHOL USE: ☐ Never ☐ Socially ☐ 1/day ☐ More than 2/day ☐ in recovery

RECREATIONAL DRUG USE: ☐ Never ☐ Sometimes ☐ Frequent ☐ What type? _____
Have you ever injected drugs? ☐ Yes ☐ No

WORK STATUS: ☐ Retired ☐ Disabled ☐ Work outside the home Occupation _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Living with significant other ☐ Widowed

DO YOU CURRENTLY DRIVE? ☐ Yes ☐ No

DO YOU HAVE AN ACTIVE DRIVERS LICENSE? ☐ Yes ☐ No

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION? ☐ High School ☐ College ☐ Graduate School

REVIEW OF SYSTEMS: Please check any of the following symptoms you have had recently:

☐ Persistent Fever
☐ Unexplained Weight Loss
☐ Fatigue
☐ Chest Pain
☐ Palpitations
☐ Difficulty Breathing
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Discolored Urine
☐ Urinary Incontinence
☐ Bowel Incontinence
☐ Muscle Pain
☐ Joint Pain
☐ Rash
☐ Easy Bruising
☐ Blood Clots in Legs or Lungs
☐ Abnormal Bleeding
☐ Trouble Sleeping
☐ Headache
☐ Neck Pain
☐ Back Pain
☐ Blindness
☐ Blurry Vision
☐ Double Vision
☐ Hearing Loss
☐ Ringing in Ears
☐ Persistent Dizziness
☐ Difficulty Speaking
☐ Difficulty Swallowing
☐ Weakness in Arms or Legs
☐ Numbness
☐ Tingling
☐ Loss of Balance
☐ Difficulty Walking
☐ Confusion
☐ Memory Loss
☐ Impotence
☐ Tremor

DATE OF LAST MENSTRUAL PERIOD: _____