ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

02-22-11

Name: _____

Date of Birth: _____ Today's Date: _____

SYSTEMS REVIEW

As you review the following list, **please check any of the problems which apply to you.**

GENERAL:
____ Recent weight gain
____ Recent weight loss
____ Fatigue
____ Weakness
____ Fever
____

NERVOUS SYSTEM:
____ Headaches
____ Dizziness
____ Fainting
____ Muscle spasm
____ Loss of consciousness
____ Numbness of hands and/or feet
____ Memory/Trouble concentrating
____ Impaired balance

EARS:
____ Ringing in ears
____ Recent loss of hearing

EYES:
____ Pain
____ Redness
____ Loss of vision
____ Double vision
____ Blurred vision
____ Dryness

NOSE:
____ Loss of smell

MOUTH:
____ Sores in mouth
____ Loss of taste
____ Dryness
____ Slurred speech

THROAT:
____ Hoarseness
____ Difficulty swallowing

HEART AND LUNGS:
____ Pain in chest
____ Irregular heart beat
____ Sudden changes in heart beat
____ Shortness of breath
____ Difficulty in breathing at night
____ Swollen legs and/or feet
____ High blood pressure
____ Wheezing
____ Night sweats

STOMACH AND INTESTINES:
____ Nausea
____ Increasing constipation
____ Persistent diarrhea
____ Blood in stools
____ Heartburn

KIDNEY/URINE/BLADDER
____ Difficulty with urination
____ Frequent urination
____ Getting up at night to urinate
____ Sexual difficulties
____ Prostate trouble
____ Loss of bladder/bowel control

BLOOD:
____ Anemia
____ Bleeding tendency

SKIN:
____ Easy bruising
____ Rash
____ Hives
____ Sun sensitive
____ Nodules/bumps
____ Hair loss
____ Color changes of hands and
____ /or feet in the cold

MUSCLE/JOINTS/BONES:
____ Joint pain
____ Muscle weakness
____ Muscle tenderness

HABITS

Do you drink alcoholic beverages?
Yes ___ No ___ If yes, how many
Per day?_____ Per week? _____
Do you smoke? Yes ___ No ___ Past ___
Cigarettes per day? _____
Do you use drugs for reasons that are
Not medical? If so, please list:
_____
Do you get enough sleep at night?
Yes ___ No ___

Do you drink caffeine?
Yes ___ No ___

Right handed ____ Left-Handed____

Daytime Activities:

Employed? Yes____ No____ Job Title _____
Retired? Yes____ No____ If so, when? _____
Other typical daily activities if not employed _____
_____
_____

ROCKY MOUNTAIN NEUROLOGICAL ASSOCIATES

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HISTORY OF PRESENT ILLNESS

Briefly describe your present symptoms: _____

Date symptoms began _____ Diagnosis given? _____

List other physicians you have seen for this problem (include physical therapy, surgery and injections)

Current medications and dosages _____

Allergies_____

PAST PERSONAL HISTORY

Do you or have you had: (check if "yes")

Cancer_____	Heart problems_____	Asthma_____	Breast implants_____
Kidney Stones _____	Stroke_____	Cataracts_____	Thyroid_____
Epilepsy_____	Depression/Anxiety _____	Stomach ulcers_____	Diabetes_____
Headaches_____	Optic neuritis_____	Colitis_____	Rheumatic fever_____
Miscarriages _____	Psoriasis _____	Anemia_____	Liver disease_____
Migraines _____	Sleep apnea _____	Concussions _____	Multiple sclerosis_____

Abnormal Bleeding or Clotting _____

Other significant illness (please list)_____

Previous operations:

Type:	Year	Surgeon	City
1)_____	_____	_____	
2)_____	_____	_____	
3)_____	_____	_____	

Any serious injury? Yes__ No__ Describe_____

FAMILY HISTORY

	If Living		**If Deceased**	
	Age	Health	Age at Death	Cause of death
Father				
Mother				

Number of brothers_____ Number living_____ Number of sisters_____ Number living_____

Number of children_____ Number living_____ List ages of each child_____

Serious illnesses of your siblings and/or children_____

Do you know of any blood relatives who has had or has any of the following: (check and give relationship)

Cancer _____	Heart disease_____	Thyroid_____	Lupus_____
Dementia _____	High blood pressure_____	Epilepsy_____	Rheumatoid arthritis_____
Stroke_____	Bleeding tendency_____	Migraine_____	Colitis_____
Diabetes_____	Alcoholism_____	Multiple Sclerosis_____	Other Auto-immune Ds_____

Other significant illnesses in family members (please list)_____