

Advanced Neurologic Care Associates
New Patient Encounter Form

Please be complete and accurate as this will become part of your medical record.

Name: _____ Age: _____ Date of birth: _____

Handedness: (circle one) Right handed / Left handed / Ambidextrous

What symptoms or diagnosis prompted this referral to see a neurologist?

Medications you currently take

Birth Control Pills: No Yes Over-the-counter (non-prescription) medications _____
Aspirin: No Yes
Vitamins: No Yes

Allergies to medicines/injections: No Yes If yes, please list. _____

Have you ever been treated for: (circle yes or no)

Diabetes mellitus	No	Yes	Depression	No	Yes
High blood pressure	No	Yes	Anxiety	No	Yes
Elevated cholesterol	No	Yes	Peptic Ulcers	No	Yes
Heart attack (MI)	No	Yes	Asthma	No	Yes

List other past or current medical diagnoses:

List hospitalizations/surgeries:

SYSTEMIC REVIEW: Do you have problems with the following? If yes, please explain.

<input type="checkbox"/> Blackouts _____	<input type="checkbox"/> Weight change _____	<input type="checkbox"/> Facial numbness/Tingling _____
<input type="checkbox"/> Confusion _____	<input type="checkbox"/> Abdominal pain _____	<input type="checkbox"/> Weakness _____
<input type="checkbox"/> Concentration _____	<input type="checkbox"/> Nausea _____	<input type="checkbox"/> Numbness _____
<input type="checkbox"/> Memory loss _____	<input type="checkbox"/> Vomiting _____	<input type="checkbox"/> Tingling _____
<input type="checkbox"/> Personality change _____	<input type="checkbox"/> Diarrhea _____	<input type="checkbox"/> Pain _____
<input type="checkbox"/> Hallucinations _____	<input type="checkbox"/> Constipation _____	<input type="checkbox"/> Stiffness _____
<input type="checkbox"/> Decreased hearing R/L _____	<input type="checkbox"/> Fever _____	<input type="checkbox"/> Clumsiness _____
<input type="checkbox"/> Difficulty chewing _____	<input type="checkbox"/> Rash _____	<input type="checkbox"/> Poor Balance _____
<input type="checkbox"/> Speech difficulty _____	<input type="checkbox"/> Chest pain _____	<input type="checkbox"/> Trouble walking/falls _____
<input type="checkbox"/> Trouble swallowing _____	<input type="checkbox"/> Shortness of breath _____	<input type="checkbox"/> Poor coordination _____
<input type="checkbox"/> Difficulty tasting _____	<input type="checkbox"/> Anxiety _____	<input type="checkbox"/> Ringing in ears _____
<input type="checkbox"/> Trouble with smell _____	<input type="checkbox"/> Depression _____	<input type="checkbox"/> Dizziness _____
<input type="checkbox"/> Hoarseness _____	<input type="checkbox"/> Painful urination _____	<input type="checkbox"/> Sleep difficulty _____
<input type="checkbox"/> Drooling _____	<input type="checkbox"/> Loss of bladder control _____	<input type="checkbox"/> Snoring _____
<input type="checkbox"/> Blurred vision _____	<input type="checkbox"/> Loss of bowel control _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> Double vision _____	<input type="checkbox"/> Cough _____	
<input type="checkbox"/> Other visual changes _____		

