Advanced Neuroscience Clinic, P. A.

Patient's Name: _____

DOB: _____/_____/_____ Appointment Date: _____/_____/_____

Referring provider: _____ **Main reason for today's visit:** _____

Mark all that applies		Symptoms having TODAY		
❑ Headaches	❑ Mid Back Pain	❑ Fever	❑ Chest Pain	❑ Urinary incontinence
❑ Memory Loss	❑ Low Back Pain	❑ Night sweats	❑ Palpitations	❑ Muscle aches
❑ Dizziness	❑ Difficulty Walking	❑ Weight Loss Lbs_____ Months____	❑ Cough	❑ Muscle weakness
❑ Ringing in Ears	❑ In coordination	❑ Weight Gain Lbs_____ Months____	❑ Wheezing	❑ Joint Pain
❑ Slurred Speech	❑ Difficulty Swallowing	❑ Blurred Vision □ R or □ L	❑ Shortness of Breath	❑ Rashes/Hives
❑ Blurred Vision	❑ Urinating Frequency	❑ Double Vision □ R or □ L	❑ Nausea	❑ Anxiety
❑ Double Vision	❑ Urinating Urgency	❑ Vision Loss □ R or □ L	❑ Vomiting	❑ Depression
❑ Numbness/Tingling	❑ Incontinence of Urination	❑ Earache	❑ Diarrhea	❑ Heat intolerance
❑ Weakness	❑ Incontinence of Bowel	❑ Nasal Congestion	❑ Abdominal Pain	❑ Cold intolerance
❑ Neck Pain	❑ Other:	❑ Sore Throat	❑ Frequency Urinating	❑ Easy Bruising
		❑ Dry mouth	❑ Urgency Urinating	❑ Easy Bleeding

Past Medical History		Past Surgeries	
❑ Migraines	❑ Diabetes	❑ Low Back Surgery	❑ Cataract/Glaucoma
❑ Headache	❑ Rheumatoid Arthritis	❑ Neck Surgery	❑ Carotid Artery Surgery □ R or □ L
❑ Seizures/ Epilepsy	❑ High Thyroid	❑ Carpal Tunnel Surgery □ R or □ L	❑ Pacemaker
❑ Sleep Apnea	❑ Low Thyroid	❑ Gall Bladder	❑ Heart Bypass
❑ High Blood Pressure	❑ Hepatitis	❑ Thyroid	❑ Tonsils/Adenoid
❑ High Cholesterol	❑ Stomach Ulcer	❑ Bladder Suspension	❑ Joint Surgery: (Select Below)
❑ Heart Stent	❑ Heart Burn	❑ Appendix	❑ Hip □ R or □ L □ Both
❑ Blockage of arteries of heart (Coronary Artery Disease)	❑ Irritable Bowel Syndrome	❑ Colon	❑ Knee □ R or □ L □ Both
	❑ Kidney Stones	❑ Cesarean Section	❑ Ankle □ R or □ L □ Both
❑ Heart Attack	❑ Kidney Failure	❑ Prostate	❑ Shoulder □ R or □ L □ Both
❑ Heart Failure (CHF)	❑ Dialysis	❑ Gastric Bypass/ Lap Band	❑ Breast Biopsy/Surgery □ R or □ L
❑ Stroke/Mini Stroke (TIA	❑ Cancer Where:	❑ Hysterectomy	❑ Other:
❑ Atrial Fibrillation	❑ Other:		

During sleep Symptoms	During the day do you
❑ Snoring	❑ Feel Tired During the Day
❑ Gasp for Air during sleep	❑ Feel Sleepy
❑ Choke during sleep	❑ Napping During the Day
❑ Leg Jerk during sleep	❑ Daytime Sleepiness
❑ Pausing Breathing	❑ Tiredness

Family History

Are you adopted? ❑ No ❑ Yes → If known, complete the following information about your **blood** relatives. Exclude adoptive parents, siblings and adopted children.

Mother	Father	Brother	Sister
❑High Blood Pressure	❑High Blood Pressure	❑High Blood Pressure	❑High Blood Pressure
❑ Diabetes	❑ Diabetes	❑ Diabetes	❑ Diabetes
❑ High Cholesterol	❑ High Cholesterol	❑ High Cholesterol	❑ High Cholesterol
❑ Low Thyroid	❑ Low Thyroid	❑ Low Thyroid	❑ Low Thyroid
❑ Parkinson's	❑ Parkinson's	❑ Parkinson's	❑ Parkinson's
❑ Alzheimer's	❑ Alzheimer's	❑ Alzheimer's	❑ Alzheimer's
❑ Stroke	❑ Stroke	❑ Stroke	❑ Stroke
Other:	Other:	Other:	Other:

Social History

Employment status:

❑ Employed – current occupation(s):_____

❑ Homemaker ❑ Unemployed ❑ Retired ❑ Student ❑ Legally Disabled

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single

How many years of school have you completed?

5 6 7 8 9 10 11 12 College ❑ 2 ❑ 4 ❑ Post Grad

Substance Use:	Previous	Current	Amount/Frequency		
Smoke	❑	❑	❑ Social	❑ Moderate	❑ Heavy
Alcohol	❑	❑	❑ Social	❑ Moderate	❑ Heavy
Caffeine	❑	❑	❑ Social	❑ Moderate	❑ Heavy
Illegal Drugs	❑	❑	❑ Social	❑ Moderate	❑ Heavy

(Office use ONLY)

Height: _____ BMI: _____ Temp: _____

Weight: _____ NC: _____ B/P: _____ Pulse: _____