Center for Neurosciences

MEDICAL CONSULTATION FORM

NAME: ________________________ DATE: ____________ CELL PHONE ____________________
(so we can call with results)

Age: _________ DOB: ______________ Height: _________ Weight: _________ Female: Pregnant? ❒ Yes ❒ No

Name of physician or person who sent you to see us ____________________ Name of primary care ____________________

Name(s) of any other physicians you would like our office note sent to: ______________________________

Handedness: ❒ Right-handed ❒ Left-handed ❒ Ambidextrous

Work Status: ❒ Occupation ______________________ ❒ Current ❒ Previous ❒ Retired

❒ Disabled (reason) ______________________

What is the main reason for your visit today? ______________________________

Please describe your symptoms: ______________________________

____

____

Approximate date of onset of symptoms: ______________________________

If this is a ***spinal problem***, please fill out the following:

Have you tried? Physical therapy ❒Yes ❒No

Steroid Injections ❒Yes ❒No

Do you have any of the following diagnoses?

Diagnosis		
Diabetes	❒ Yes	❒ No
Hypertension	❒ Yes	❒ No
Asthma or emphysema	❒ Yes	❒ No
Stroke	❒ Yes	❒ No
Heart disease	❒ Yes	❒ No
Heart attack	❒ Yes	❒ No
Bleeding disorder	❒ Yes	❒ No
Hepatitis	❒ Yes	❒ No
Cancer	❒ Yes	❒ No

Type of cancer: ______________________

Year of diagnosis: ______________________

Other diagnosis: ______________________

Review of Systems

❒ Weight loss	❒ Blood in the urine
❒ Fever or chills	❒ Easy bruising
❒ Skin rash	❒ Memory loss
❒ Decreased hearing	❒ Depression
❒ Double vision	❒ Nausea
❒ Shortness of breath	❒ Vomiting
❒ Heart palpitations	❒ Snore
❒ Loss of bowel control	❒ Trouble sleeping
❒ Loss of bladder control	❒ Sleepy during day

Influenza Vaccine: ❒ Yes ❒ No Date: ______________

Pneumococcal Vaccine: ❒ Yes ❒ No Date: ____________

Marital Status: ❒ Married ❒ Divorced ❒ Separated ❒ Widowed ❒ Single

How many children do you have? ______________

Do you smoke? ❒ Yes ❒ No Packs per day: __________ Did you previously smoke? ❒ Yes ❒ No Year you quit: _______

Do you drink alcohol? ❒ Yes ❒ No Amount: ______________________________

Do you use street drugs? ❒ Yes ❒ No Type and Amount: ______________________________

Do you have Advanced Directives/Living Will? ❒ Yes ❒ No

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Please list all medications you currently take: ❒ None

It is acceptable to attach a list.

Medication	Dosage	Frequency		Medication	Dosage	Frequency
1.				7.		
2.				8.		
3.				9.		
4.				10.		
5.				11.		
6.				12.		

Have you received a COVID vaccine? Yes No If yes, provide date/manufacturer:

Please list all allergies to medicines. ❒ None

Allergy to:	Reaction:		Allergy to:	Reaction:
1.			3.	
2.			4.	

Please describe any major injuries you have had: ❒ None

1. ______________________________ Date: __________

2. ______________________________ Date: __________

Please describe surgeries you have had: ❒ None

1. ____________________ Date: ________ 4. ____________________ Date: ________

2. ____________________ Date: ________ 5. ____________________ Date: ________

3. ____________________ Date: ________ 6. ____________________ Date: ________

Have you ever had a reaction to anesthesia? ❒ Yes ❒ No

If yes, describe: ______________________________

Please list all **serious** illnesses your **blood relatives** have had.

Father: ______________________________ Deceased at age: __________

Mother: ______________________________ Deceased at age: __________

Brother(s): ______________________________

Sister(s): ______________________________

Children: ______________________________

Test Scheduling and Result Follow Up Statement

During today's visit, you may have some tests ordered. We would like your help in insuring that the tests are scheduled and results are communicated to you in a timely fashion. Test authorization and test scheduling takes one to two weeks. Test results are generally returned within 1 week. If you do not hear from us within these time frames, please contact us.

The above information is accurate and complete to the best of my knowledge.

Patient's Signature: ______________________________ Date: __________