KANE HALL BARRY NEUROLOGY NEW PATIENT INFORMATION

Name: _____ DOB: _____

Who referred you? _____ Who is your general physician(PCP)? _____

Please list the symptoms you are having and wish to bring to our attention:

_____

_____

_____

Are your symptoms due to an injury? ☐Yes ☐No

If yes, please specify date and type of injury: _____

Have you seen a neurologist before? ☐Yes ☐No

If yes, please specify date and who you saw: _____

MEDICATIONS (PLEASE ATTACH LIST IF NECESSARY)

MEDICATION	DOSE (MG)	HOW OFTEN

SOCIAL HISTORY

Occupation: _____ ☐Homemaker ☐Retired

Marital Status: ☐Single ☐Married ☐Divorced ☐Widow ☐Widower

Education: ☐Grade School ☐High School ☐College ☐Post-Graduate

Do you smoke? ☐Yes ☐No If so, how many cigarettes/packs per day? _____

Did you smoke in the past? ☐Yes ☐No If so, for how long? _____

Do you drink Alcohol? ☐Yes ☐No If yes: ☐Beer ☐Wine ☐Liquor How much? _____

Have you used recreational drugs? ☐Yes ☐No If yes: ☐Marijuana ☐Cocaine ☐Heroin ☐Methamphetamines ☐MDMA/"X"

FAMILY HISTORY

☐Alcoholism	Who? _____	☐Migraine	Who? _____
☐Alzheimer's Disease	Who? _____	☐Multiple Sclerosis	Who? _____
☐Cancer	Who? _____	☐Muscle Disease	Who? _____
☐Depression	Who? _____	☐Neuropathy	Who? _____
☐Diabetes	Who? _____	☐Parkinson's Disease	Who? _____
☐Epilepsy	Who? _____	☐Schizophrenia	Who? _____
☐Heart Disease	Who? _____	☐Stroke	Who? _____
☐High Blood Pressure	Who? _____	☐Tremor	Who? _____
☐Lung Disease	Who? _____	☐_____	Who? _____

PATIENT SERIOUS ILLNESSES

☐Alzheimer's Disease	☐Diabetes	☐Hydrocephalus	☐Multiple Sclerosis	☐Seizures
☐Arthritis	☐Fibromyalgia	☐Kidney Problems	☐Muscle Disease	☐Sleep Apnea
☐Asthma	☐Head Injury	☐Liver Problems	☐Neck Problems	☐Thyroid Problems
☐Bipolar Disorder	☐Heart Problems	☐Lung Problems	☐Neuropathy	☐_____
☐Cancer	☐High Blood Pressure	☐Memory Loss	☐Parkinson's Disease	☐_____
☐Depression	☐High Cholesterol	☐Migraine	☐Passing Out/Syncope	☐_____

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Name: _____ DOB: _____

DRUG ALLERGIES

- ☐ *No known drug allergies*
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Vicodin
- ☐ _____
- ☐ _____
- ☐ _____

OPERATIONS

- ☐ Appendectomy
- ☐ Back
- ☐ Brain Tumor
- ☐ Breast Augmentation
- ☐ Cancer
- ☐ Carpal Tunnel
- ☐ Cervical Spine
- ☐ Gall Bladder
- ☐ Heart Bypass
- ☐ Heart Valve Replacement
- ☐ Hip
- ☐ Knee Replacement
- ☐ Hysterectomy
- ☐ Lumbar Spine
- ☐ Orthopedic
- ☐ PEG Tube
- ☐ Pituitary
- ☐ Shoulder
- ☐ Subdural Hematoma
- ☐ Pacemaker

SYMPTOM REVIEW

CONSTITUTIONAL
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Malaise
- ☐ Night Sweats
- ☐ Weight Gain
- ☐ Weight Loss
- ☐ Other _____

HEENT
- ☐ Ear Drainage
- ☐ Ear Pain
- ☐ Eye Discharge
- ☐ Eye Pain
- ☐ Hearing Loss
- ☐ Nasal Drainage
- ☐ Sinus Pressure
- ☐ Sore Throat
- ☐ Visual Changes
- ☐ Other _____

RESPIRATORY
- ☐ Chronic Cough
- ☐ Cough
- ☐ Known TB Exposure
- ☐ Shortness of Breath
- ☐ Wheezing
- ☐ Other _____

CARDIOVASCULAR
- ☐ Chest Pain
- ☐ Cludication
- ☐ Edema
- ☐ Palpitations
- ☐ Other _____

GASTROINTESTINAL
- ☐ Abdominal Pain
- ☐ Blood in Stool
- ☐ Change in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of Appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Other _____

GENITOURINARY
- ☐ Dysuria
- ☐ Hematuria
- ☐ Polyuria
- ☐ Urinary Frequency
- ☐ Urinary Incontinence
- ☐ Urinary Retention
- ☐ Dribbling (Male)
- ☐ Slow Stream (Male)
- ☐ Other _____

REPRODUCTIVE
- ☐ Erectile Dysfunction
- ☐ Penile Discharge
- ☐ Sexual Dysfunction
- ☐ Other _____

METABOLIC/ENDOCRINE
- ☐ Brittle Hair
- ☐ Brittle Nails
- ☐ Cold Intolerance
- ☐ Hair Changes
- ☐ Heat Intolerance
- ☐ Hirsutism
- ☐ Polydipsia
- ☐ Polyphagia
- ☐ Other _____

NEUROLOGICAL
- ☐ Dizziness
- ☐ Extremity Numbness
- ☐ Extremity Weakness
- ☐ Gait Disturbance
- ☐ Headache
- ☐ Memory Loss
- ☐ Seizures
- ☐ Tremors
- ☐ Other _____

PSYCHIATRIC
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Other _____

INTEGUMENTARY
- ☐ Contact Allergy
- ☐ Hives
- ☐ Itching
- ☐ Mole Changes
- ☐ Rash
- ☐ Skin Lesion
- ☐ Other _____

MUSCULOSKELETAL
- ☐ Back Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Other _____

HEMATOLOGIC/LYMPHATIC
- ☐ Easy Bleeding
- ☐ Easy Bruising
- ☐ Lymphadenopathy
- ☐ Other _____

IMMUNOLOGIC
- ☐ Environmental Allergy
- ☐ Food Allergy
- ☐ Seasonal Allergy
- ☐ Other _____

Please sign and date below. This questionnaire will become part of your medical record.

SIGNATURE: _____ DATE: _____