

**Neurology and Sleep Medicine, P.C.**  
**701 Ostrum Street Suite 302**  
**Bethlehem, PA 18015**

**NEW NEUROLOGIC HISTORY**

Please tell us about yourself by completing this form. We will use this information to better understand your concerns and direct your care. Thank you.

**Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Birthdate:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **Age:** \_\_\_\_\_

**Right or Left handed?**

Who is your Primary Doctor? \_\_\_\_\_

List any other doctors you see: \_\_\_\_\_

\_\_\_\_\_

**What symptoms are you having or what reasons your doctor referred you to us?:**

\_\_\_\_\_

**Please circle all that apply to your symptoms**

- Pain    Numbness/tingling    Heavy feeling    Weakness    Paralyzed  
Unsteadiness    Spinning sensation    Clumsy    Tremor    Twitching  
Shaking Forgetful    Confusion    Blackout    Lost time    visual changes
  
- Head                      Neck                      Back- C/T/L                      Waist                      Chest  
Arms- R/L                      Hands-R/L                      Fingers- R/L  
Legs- R/L                      Feet- R/L                      Toes- R/L
  
- Constant                      Intermittent                      Fluctuates                      Only occurred once  
Lasts seconds/minutes/hours
  
- Suddenly occurs                      Slowly/gradually occurs                      Always had symptoms

Please describe anything else you think we should know: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



circle the problems you are having now

**Review of Systems:**

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#1  
(HPI,  
ROS,  
PFSH)  
  
ROS  
  
Problem  
Focused- none  
  
Extended  
PF- 1 sys  
  
Detailed-  
2-9 sys  
  
Comprehensive  
- > 9 sys

- [ ] nl **Constitutional:** fevers / chills, weight gain or loss, fatigue/tiredness, appetite changes
- [ ] nl **HEENT:** sinus problems/congestion, blurred vision, dry eyes, eye pain, hearing loss, ringing/fullness in ears, mouth sores, sore throat, hoarseness, trouble swallowing, masses, bleeding
- [ ] nl **Cardiovascular:** chest pain/pressure, palpitations (heart skips a beat), rapid or irregular heart beat, swelling in the legs/arms, poor circulation
- [ ] nl **Respiratory:** shortness of breath with or without exertion, unusual/persistent cough
- [ ] nl **GI:** nausea, vomiting, diarrhea, abdominal pain, changes in bowel habits, dark tarry stool, loss of bowel control
- [ ] nl **GU:** loss of bladder control (incontinence), urgency, increased frequency, trouble getting started, painful urination, blood in urine
- [ ] nl **Musculoskeletal:** joint pain, muscle pain, immobility or loss of function, head/neck/ back pain, pain when walking
- [ ] nl **Integumentary:** rash, masses, or skin lesions, levido reticularis
- [ ] nl **Psychiatric:** anxiety, depression, mood swings, psychiatric hospitalizations, sleep problems
- [ ] nl **Endocrine:** unusual weight loss/gain, excessive urination, excessive thirst, hair loss/gain, hot/cold intolerance, nipple discharge, loss of sexual drive or ability, erection difficulty, menstrual period change/irregularity
- [ ] nl **Heme/lymph:** unusual bleeding, easy bruisability, clotting or skin lumps
- [ ] nl **Neurological:**
  - General:** Headache, nausea/vomiting, lightheaded, seizure, blacked out, passed out or fainted (syncope), trauma, flashing lights, increased sleepiness, troubles getting to sleep, snoring, awakenings at night
  - Mental status:** confusion, alteration/loss of consciousness, difficulty expressing / understanding speech, confusion, memory problems, personality changes
  - CNS:** loss of vision, blurry or double vision, numbness/weakness in face, face drooping, taste/smell loss or changes, hearing loss/ringing, vertigo/dizziness, trouble swallowing (dysphagia), slurred speech (dysarthria)
  - Motor:** tremor, fasciculations, atrophy, weakness (proximal vs. distal), cramping (pre/post exercise)
  - Coordination:** unsteadiness, balance difficulties, clumsiness, problems reaching for objects
  - Sensory:** numbness, heaviness, tingling, pain, falls (w/eyes closed/taking shower)
  - Gait:** difficulty walking, falling to one side, sensation of being pushed, falls

#1  
(HPI,  
ROS,  
PFSH)

Past,  
Family,  
Social  
History

Problem  
Focused- none

Extended  
PF- none

Detailed-  
1 area

Comprehensive  
-2 areas(est)  
-3 for new.

**Past Health History** [ ] unable to obtain (reason) Circle conditions you have or have had

Stroke	High blood pressure (HTN)	Thyroid problems (hypo/hyper)
Migraine	High blood sugar (DM I/II)	GERD
Seizure/Epilepsy	High cholesterol/lipids	Liver / Kidney disease
Movement disorder	Heart disease (CAD, CHF)	Asthma / COPD / lung disease
Alzheimers	Heart attack (how many?___)	Spontaneous miscarriages
Blood Clots	Bleeding disorder	Arthritis / lupus /
Head injury	Difficulty sleeping	Cancer (location/type)
Injury/trauma	Psychiatric Hospitalizations	Sleep problems

Other: \_\_\_\_\_

[ ] no history of stroke/TIA, meningitis/encephalitis, seizures (febrile?/family hx)/loss of consciousness, head trauma, back or neck injury.

**Prior Hospitalizations and/or Surgeries:** [ ] unable to obtain (reason)

Hospital	Date	Reason

**Prior Tests (MRIs, CTs, EEGs, EMG/NCs, Sleep tests:** [ ] unable to obtain (reason)

Test	Date	Result

**Medications (including vitamins and Over the Counter medicines):**

Medication / Dose	How long?	Medication / Dose	How long?

**Allergies:** [ ] NKDA (no known drug allergies) (sulfa, pcn, asa, other, latex, contrast material)

Please list any drug allergies and reactions you had: \_\_\_\_\_

\_\_\_\_\_

