Tuality Neurology Clinic

Name _____ Referred by _____

PCP _____ E-mail _____

Reason for seeking neurologic evaluation:

What are your goals for this visit?

Have you had any of the following tests for this issue? If so when and where

MRI/CT _____ Others:

EEG _____

NCV/EMG _____

Blood tests _____

Neurologic History: Please circle any diagnosis **you** have

Stroke TIA Intracranial hemorrhage Carotid stenosis (narrowing)

Epilepsy Other seizures Syncope/passing out

Migraine headaches Other headaches

Parkinson's disease Essential tremor

Multiple Sclerosis Traumatic brain injury

Alzheimer's disease Other dementia

Diabetic neuropathy Other neuropathy

Meningitis

Other Neurologic Diseases: _____

Medical history: Please circle illnesses **you** have had

Heart: Heart attack/coronary artery disease Atrial fibrillation Congestive heart failure

Hypertension / high blood pressure Cholesterol/lipid abnormality

Asthma Emphysema /COPD Pulmonary embolism

Kidney/renal failure Kidney stones

Ulcers Liver disease Gastro esophageal reflux Irritable bowel syndrome

Diabetes Thyroid disease

Cataracts glaucoma macular degeneration

Cancer: If yes type(s) _____

Other: _____

Surgeries

Date	Surgery/reason for surgery	Doctor

Please use the back of this sheet for other surgeries or information