OHSUHealth
Hillsboro Medical Center

Patient Identification

Neurology Clinic New Patient History

Name: _____ **Referred by**: _____

PCP: _____ **Email**: _____

Date: _____

Reason for evaluation: _____

_____

What are your goals: _____

_____

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

MRI/CT: _____ **Blood tests:** _____

EEG: _____ **Others:** _____

NCV/EMG: _____

Hospitalizations in the past two years? If yes, why/when/where: _____

_____

Neurologic History – Please check any diagnosis you have:

	Stroke		Diabetic neuropathy		Traumatic brain Injury
	TIA		Meningitis		Alzheimer's disease
	Epilepsy		Intracranial hemorrhage		Syncope/passing out
	Migraine Headache		Other seizures		Carotid stenosis (narrowing)
	Parkinson's disease		Other Headaches		Other neuropathy
	Multiple Sclerosis		Essential tremor		Other Dementia
	Other Neurologic diseases:				

Medical History – Please check any diagnosis you have had:

	Heart: heart attack/coronary artery disease		Atrial fibrillation		Macular degeneration
	Irritable bowel syndrome		Thyroid disease		Cataracts
	Congestive heart failure		Kidney/renal failure		Glaucoma
	Hypertension/high blood pressure		Kidney stones		Diabetes
	Cholesterol/lipid abnormality		Ulcers		Asthma
	Gastroesophageal reflux		Emphysema/COPD		
	Cancer:	Type:			
	Other:				

Surgical History – Please check any that you have had:

	Appendectomy		Cholecystectomy/Gallbladder Removal		Myringotomy
	Back Surgery		Colectomy		Pacemaker Placement
	Bariatric Surgery		Cosmetic Surgery		Prostatectomy
	Brain Surgery		Hernia Repair		Splenectomy
	CABG/Heart Surgery		Hip Replacement		Thyroidectomy
	Cataract Removal		Hysterectomy		Tubal Ligation
	Cesarean Section		Knee Arthroscopy		Vasectomy
	Other:				

Family History	Alive? Yes	No	Age	Medical Issues
Father				
Mother				
Siblings				
Children				

Social History

Area of Focus	Yes	No	Additional Information
Do you live alone?			If not, who lives with you?
Do you exercise regularly?			If yes, describe:
Do you have any special dietary restrictions?			If yes, describe:
Do you use tobacco or nicotine?			
• Do you smoke cigars or cigarettes?			How much/how long:
• Do you use chewing tobacco?			How much/how long:
• Do you vape or use e-cigarettes?			How much/how long:
Do you drink alcohol?			How much?
Recreational drugs?			If yes, what:
Occupation:			
Education:			
Right-Handed		Left-Handed	

Allergies

Allergy	Reaction	If controlled with medications, please list

Medications - Please attach additional pages if needed

Name of Medication	Dose, unit, MG	Route: Oral, eye drop	Direction: How often	Purpose, reason

Review of systems – Please circle if you have any of the following symptoms (all that apply to you in the last month)

Neurologic:

Double vision
Loss of bladder or bowel control
Vomiting
Dizziness or vertigo
Slurred speech
Loss of balance
Headaches
Weakness
Memory loss
Tremors or involuntary movements
Neck or back pain
Falls or trouble walking
Numbness or tingling
Muscle atrophy

Constitutional:
Weight loss/ weight gain
Fever
Fatigue
Night sweats
Hot flashes
Dizziness

Eyes:
Discharge
Burning
Double vision
Eye pain

Ears/ Nose/ Mouth/ Throat:
Decreased hearing
Ear pain
Congestion
Sore throat
Ringing in ears

Respiratory:
Shortness of breath
Cough/ wheezing
Sputum production
Spitting up blood

Immunologic:
Recurrent fevers
Recurrent infections
Malaise

Breast:
Lump/ mass
Pain
Swelling
Discharge
Changes in breast(s)

Gastrointestinal:
Nausea
Vomiting
Diarrhea/ constipation
Abdominal pain

Genitourinary:
Painful urination
Blood in urine
Urgency
Incontinence
Frequent urination

Heme / Lymp:
Bruising
Bleeding
Swollen lymph glands

Endocrine:
Cold or hot intolerance
Excessive hunger or thirst
Loss of hair

Musculoskeletal:
Back pain
Neck pain
Joint pain
Muscle pain
Decreased range of motion

Integumentary:
Rash
Itching
Dryness
Burns
Lesions

Cardiovascular:
Chest pain
Palpitations
Fainting
Swelling in legs

Psychiatric:
Anxiety
Depression
Suicidal thoughts
Sleep disturbance
Mood swings