Northeast Georgia
PHYSICIANS GROUP
Neurology

DATE:______________ NAME:____ DOB:___________

What problem are we seeing you for? ____

On a pain scale of (**0 to 10**), at what number would you rate your pain? ____

How long have you had this problem? ____

Who referred you?________________________________ Primary Care Physician: ___________________________

Allergies? Yes No If yes, please list allergies and reactions:____

PAST MEDICAL HISTORY (Circle any of the following conditions you have been diagnosed with):

Headaches	High Blood Pressure	Congestive Heart Failure	Anemia
Implanted Devices	Low Blood Pressure	Stomach Ulcers	Epilepsy
Stroke	Syncope	Diabetes	Arthritis
TIA	High Cholesterol	Low Blood Sugar	Fibromyalgia
Carotid Artery Disease	Thyroid Disease	Liver Disease	Psychiatric Disorder
Coronary Artery Disease	Asthma	Hepatitis	Anxiety
Heart Attack	Emphysema/COPD	Kidney Stones	Depression
Abnormal Heart Rhythm	Cancer	Kidney Disease	Claustrophobia

Other:____

PAST SURGICAL HISTORY (Circle any of the following surgeries you have undergone):

Back Surgery	Carotid Surgery	Carpal Tunnel Repair	Gall Bladder
Neck Surgery	Cardiac Stent	Hysterectomy	Gastric Bypass
Brain Surgery	Pacemaker	Appendectomy	

Other:____

SOCIAL HISTORY:

Alcohol Use: Yes No Frequency:____________________

Tobacco Products: Current Former Never E-cigarettes

Currently working? Yes No Occupation:_______________

Disability? Yes No Pending Seeking

Caffeine Beverages per day? ______________________

Under Stress? Yes No

Marital Status: _________________________________

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list relationship to affected individual(s):

Heart Disease ____________________

Hypertension _____________________

Stroke __________________________

Back Surgery _____________________

Headaches _______________________

Cancer __________________________

Kidney Disease ____________________

Neuropathy _______________________

Seizure Disorder ___________________

Diabetes _________________________

Brain Aneurysm ___________________

Psychiatric History _________________

Drug Abuse ______________________

Parkinson's Disease ________________

Arthritis ________________________

Trembling _______________________

REVIEW OF SYSTEMS (Circle any of the following symptoms you have experienced in the past 6 months):

Constitutional

Activity change

Appetite change

Fatigue

Fever

Unexpected weight change

HENT

Congestion

Ear pain

Hearing loss

Nosebleeds

Runny nose

Sinus pain

Sore throat

Ringing in the ears

Difficulty swallowing

Voice change

Eyes

Eye pain

Eye redness

Sensitivity to light

Visual disturbance

Respiratory

Chest tightness

Cough

Shortness of breath

Cardiovascular

Chest pain

Leg swelling

Palpitations

Gastrointestinal

Abdominal distention

Abdominal pain

Constipation

Diarrhea

Nausea

Vomiting

Endocrine

Cold intolerance

Heat Intolerance

Genitourinary

Large volume of urine

Painful urination

Urinary Frequency

Musculoskeletal

Joint pain

Back pain

Difficulty Walking

Joint swelling

Muscle pain

Neck pain

Skin

Color change

Rash

Allergies/Immune System

Food allergies

Immuno-compromised

Neurological

Dizziness

Headaches

Light-headedness

Numbness

Seizures

Speech difficulty

Syncope

Tremors

Weakness

Hematologic

Bruises/bleeds easily

Psychiatric

Agitation

Behavior problem

Confusion

Decreased concentration

Persistent bad mood

Hallucinations

Nervous/anxious

Sleep disturbance

MEDICATION LIST

NAME:______________________________ DOB:____________________

PHARMACY:__________________________ PHONE:__________________

MAIL-IN PHARMACY:____

PLEASE PROVIDE US WITH COMPLETE LIST OF MEDICATIONS BELOW, INCLUDING DOSAGE AND HOW MANY TIMES PER DAY YOU TAKE EACH MEDICATION.

MEDICATION	DOSE	TIMES PER DAY