Northeast Georgia Physicians Group- Neurology

DATE:______________ NAME:_______________________________________ Date of Birth:_________

Weight:______ Height:______ BP:____/____ Pulse:_______ Resp:______ O2:______ Temp:______

What problem are we seeing you for? ____

How long have you had this problem? ____

Who referred you?________________________________ Primary Care Physician: __________________________

PAST MEDICAL HISTORY: Have you ever been diagnosed with any of these conditions?

☐ Headaches	☐ Abnormal Heart Rhythm	☐ Asthma	☐ Kidney Stones
☐ Stroke/TIA	☐ Congestive Heart Failure	☐ Emphysema/COPD	☐ Kidney Disease
☐ Epilepsy/Seizures	☐ Heart Attack	☐ Stomach Ulcers	☐ Diabetes
☐ Anxiety/Depression	☐ Carotid Artery Disease	☐ Thyroid Disease	☐ Low Blood Sugar
☐ Dementia	☐ Coronary Artery Disease	☐ Liver Disease/Hepatitis	☐ Arthritis
☐ High Blood Pressure	☐ High Cholesterol	☐ Anemia	☐ Fibromyalgia
☐ Low Blood Pressure	☐ Peripheral Vascular	☐ Syncope	☐ Claustrophobia

Other:____

Have you ever had cancer? ☐ Yes ☐ No Where?

PAST SURGICAL HISTORY: Have you ever had any of the following surgeries?

☐ Back Surgery	☐ Pacemaker
☐ Neck Surgery	☐ Cardiac Stent
☐ Carpal Tunnel Repair	☐ CABG
☐ Carotid Surgery	☐ Implanted Devices
☐ Brain Surgery	☐ Hysterectomy

Other:____

SOCIAL HISTORY:

Alcohol Use: ☐ Yes ☐ No How Often? ____________________________

Tobacco Products: ☐ Yes ☐ No Packs per day? _______________________

Are you currently working? ☐ Yes ☐ No Occupation? ___________________

Disability? ☐ Yes ☐ No ☐ Pending ☐ Seeking

Caffeine Beverages per Day?

Under Stress? ☐ Yes ☐ No

☐ Married ☐ Divorced ☐ Widowed ☐

FAMILY HISTORY: Do any of your blood relatives have or have they ever had any of these conditions? Please list who.

☐ Heart Disease	____________	☐ Kidney Disease	____________	☐ Dementia	____________
☐ Hypertension	____________	☐ Neuropathy	____________	☐ Drug Abuse	____________
☐ Stroke	____________	☐ Seizure Disorder	____________	☐ Parkinson's	____________
☐ Back Surgery	____________	☐ Diabetes	____________	☐ Arthritis	____________
☐ Headaches	____________	☐ Brain Aneurysm	____________	☐ Trembling	____________
☐ Cancer	____________				

PROOF

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

Memory Loss

Tingling

Off-Balance

Hematologic

Bruises/bleeds easily

Psychiatric

Agitation

Behavior problem

Confusion

Decreased concentration

Persistent bad mood

Hallucinations

Nervous/anxious

Sleep disturbance

PROOF

Northeast Georgia Physicians Group

MEDICATION LIST

NAME:____ **DOB:**___________________________

PHARMACY:____ **PHONE:**________________________

MAIL-IN PHARMACY:____

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

____

____

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

MEDICATION	DOSE	TIMES PER DAY

PROOF