

Nor Lea Neurology New Patient Form Page 1

Patient's Name: _____ Today's Date: _____

Date of Birth: _____

Past Medical History

Other Physician's name: _____ What type of doctor?: _____

Other Physician's name: _____ What type of doctor?: _____

Other Physician's name: _____ What type of doctor?: _____

Other Physician's name: _____ What type of doctor?: _____

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Seizure | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Asthma | <input type="checkbox"/> Seizures | <input type="checkbox"/> Kidney Stones |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Stroke | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver problems / Hepatitis |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Headaches / Migraines | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Heartburn (reflux) | <input type="checkbox"/> Seasonal allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney Failure |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Depression / Anxiety | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Swollen ankles | <input type="checkbox"/> Ear problems | <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Fibromyalgia |

Please describe any current or past medical treatment not listed above

Please list your past surgeries

Allergies

Are you allergic to penicillin or any other drugs? Yes No

Please list: _____

PLEASE COMPLETE REVERSE SIDE

Nor Lea Neurology New Patient Form Page 2

Social and Preventive History

Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No
How many packs per day?

Do you drink alcohol, beer, or wine? Yes No If no, have you in the past? Yes No
How many drinks per week?

Do you currently drink coffee and/or tea? Yes No If yes, how many cups per day?

Do you exercise daily/weekly? Yes No

Have you ever been sexually or physically abused? Yes No

Family History

Living Age (or age at death) List serious illnesses

Mother Yes No

Father Yes No

Sisters Yes No

Yes No

Yes No

Brothers Yes No

Yes No

Yes No

Has any member of your family (including children and parents) had any of the following illnesses:

Illness Which family member?

Anemia or Blood disease

Cancer

Diabetes

Migraine

Heart disease

High blood pressure

Bleeding in the Brain

Seizure

Stroke

Other serious illness

Females: Gynecological History

How many times have you been pregnant? Date of last Pap Smear:

Date of last mammogram: Mammogram results:

Have you ever had a breast biopsy? Yes No Biopsy results:

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature Date

