CONNECTICUT NEUROLOGICAL SPECIALIST, LLC
NEW PATIENT BACKGROUND INFORMATION

NAME:_____ PREFERS TO BE CALLED: _____ TODAY'S DATE:_____
REFERRING PHYSICIAN:_____ PRIMARY PHYSICIAN (IF DIFFERENT): _____
DATE OF BIRTH: _____ AGE: _____
ARE YOU: RIGHT HANDED _____ LEFT HANDED _____ AMBIDEXTROUS _____
CHIEF COMPLAINT / MAIN PROBLEM: _____

_____

LIST ANY TESTING DONE FOR CURRENT PROBLEM

TEST	WHERE	WHEN
BLOOD TESTS		
EEG		
CT/MRI		
ECHO/DOPPLER		
OTHER TESTS?		

PAST MEDICAL HISTORY (CHECK THOSE WHICH APPLY)

HIGH BLOOD PRESSURE _____	DIABETES _____	HIGH CHOLESTEROL _____
HEART ATTACKS _____	ARRYTHMIAS _____	LUNG DISEASES _____
THYROID PROBLEMS _____	LIVER/HEPATITIS _____	KIDNEY PROBLEMS _____
CANCER _____	ULCERS _____	BLEEDING PROBLEMS _____
ARTHRITIS _____	HIV _____	VENEREAL DISEASES _____
DEPRESSION _____	ANXIETY _____	PSYCHIATRIC _____
STROKES _____	SEIZURES/EPILEPSY _____	MIGRAINE/HEADACHES _____
NERVE or MUSCLE DISORDERS _____	_____	_____
SURGERY _____	_____	_____
OTHER DISEASE OR CONDICTION NOT LISTED_____		_____

MEDICATIONS CURRENTLY USED: (INCLUDING NON-PRESCRIPTION MEDS, VITAMINS, ETC.) (DOSE?)

_____

_____

_____

ALLERGIES (Medication or Non Medication/List Reaction): _____

SOCIAL HISTORY: **ARE YOU: (CHECK THOSE THAT APPLY)**

MARRIED _____ SINGLE _____ DIVORCED _____ WIDOWED _____
OCCUPATION: _____ RETIRED?: YES _____ NO_____
DO YOU SMOKE CIGARETTES? NO _____ YES _____ HOW MANY PER DAY? _____
DO YOU DRINK ALCOHOL? NO _____ YES _____ HOW MUCH? _____

FAMILY HISTORY: LIST ANY NEUROLOGICAL OR MEDICAL PROBLEMS THAT RUN IN THE FAMILY:

MOTHER _____ FATHER _____
CHILDREN _____ SISTER(S)_____ BROTHER(S)_____
OTHER RELATIVES WITH SIGNIFICANT ILLNESSES: _____

REVIEW OF SYSTEMS: CIRCLE ANY SYMPTOMS THAT YOU HAVE:

Fever/Chills, Weight Changes, Fatigue, Head Trauma, Eye or Ear Problem, Nasal Discharge, Sore Throat, Cough, Cough Blood, Shortness of Breath, Chest Pain, Palpitation, Syncope, Nausea, Vomiting, Diarrhea, Constipation, Blood in Stool, Urinary Frequency/Urgency, Blood in Urine, Abnormal Discharge, Skin Rashes, Lumps, Sores, Itching, Changes in Hair or Nails, Joint Pain or Stiffness, Headache, Seizure, Focal Weakness or Numbness, Depression, Suicidal Thought, Anxiety, Delusion or Hallucination, Other _____

RECORDED BY _____