CMH Neurology and Headache Center
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New Patient Paperwork

PLEASE NOTE: This form is a VERY IMPORTANT part of your evaluation.
Please take time and answer each question carefully. It only takes about 30 minutes to fill out.

PLEASE HAVE THIS FORM COMPLETED BEFORE YOUR APPOINTMENT

Your Name (Last, First)	Your Date of Birth	Today's Date
What name do you like to be called? (e.g. full first name, nickname, etc.):		

SECTION 1: PERSONAL INFORMATION

This form was filled out by:

☐ Patient
☐ Someone else
If filled out by someone other than the patient, please list who filled out (or helped fill out) this form:

Current Age	What hand do you write with?	Who referred you to our clinic? (Please list MD/DO or PA/NP that referred you)
	☐ Right ☐ Left ☐ Ambidextrous	

What are the main symptoms we will be seeing you for:

Specific concerns or questions you would like addressed at this appointment:

SECTION 2: MEDICAL HISTORY

YOUR MEDICAL CONDITIONS

Please click on any and all medical conditions that you are *currently being treated for* or have been *diagnosed with in the past*.

Have you been diagnosed with any of the following medical conditions?	Yes	No	Don't Know
Stroke or TIA	☐	☐	☐
Brain tumor	☐	☐	☐
Alzheimer's disease	☐	☐	☐
Parkinson's disease	☐	☐	☐
Multiple Sclerosis	☐	☐	☐
Fainting or syncope	☐	☐	☐
Seizures or epilepsy	☐	☐	☐
Migraine	☐	☐	☐
Head injury	☐	☐	☐
Heart problems (heart attack, stent, bypass, valve problem)	☐	☐	☐
Heart rhythm problems (atrial fibrillation, tachycardia)	☐	☐	☐
Pacemaker or defibrillator	☐	☐	☐
High blood pressure (or on medicine for it)	☐	☐	☐
High cholesterol (or on medicine for it)	☐	☐	☐
Diabetes (or on treatment for it)	☐	☐	☐
Low vitamin B-12 (or on medicine for it)	☐	☐	☐
Liver disease (elevated liver enzymes, hepatitis, cirrhosis)	☐	☐	☐
Kidney disease (CKD, renal failure, dialysis)	☐	☐	☐
Low thyroid (or on medicine for it)	☐	☐	☐
Tobacco use	☐	☐	☐
Alcohol use	☐	☐	☐
Overuse use of prescription or "street" drugs	☐	☐	☐
Fibromyalgia	☐	☐	☐
Any other form of dementia	☐	☐	☐
Depression or other mental health disorder	☐	☐	☐
Bipolar	☐	☐	☐
Anxiety or panic disorder	☐	☐	☐
PTSD	☐	☐	☐
Sleep apnea (or prescribed CPAP or BiPAP)	☐	☐	☐
Any implanted stimulator (e.g. spine, bladder, vagal nerve)	☐	☐	☐
Cancer: If yes, what type? _____	☐	☐	☐

Please list **any other medical conditions** that you are *currently being treated for* or have been *diagnosed with in the past.*

SECTION 3: SURGICAL HISTORY

YOUR SURGERIES, OPERATIONS AND PROCEDURES

Have you had any of the following surgeries, operations or procedures?	Yes	No	When? (Year)
Heart procedures (bypass/stent/ablation/valve/pacemaker)	☐	☐	
Cardiac stress test	☐	☐	
Cancer surgery	☐	☐	
Brain surgery	☐	☐	

Please list any and all other surgeries/operations/procedures that you have had:

Tip: A good way to do this is to start with the first one you ever had and then list the others after that.

Surgery/Operation/Procedure	Year

SECTION 4: MEDICATIONS

YOUR MEDICATIONS

Please list all of your current prescription medications, over the counter and vitamin/herbal treatments.

NAME	STRENGTH	HOW OFTEN
Example: Topamax	50 mg	1 twice a day

SECTION 5: ALLERGIES

YOUR DRUG ALLERGIES

Please list all drug allergies and medications you can't take due to side-effects.

NAME OF MEDICATION	TYPE OF REACTION

Your Local Pharmacy	Your Mail Order Pharmacy
Name: _____ Location:_____	Name: _____ Location:_____

SECTION 6: SOCIAL HISTORY

Marital Status	Do you have a Durable Power of Attorney?	
☐Single ☐Married ☐Divorced ☐Widowed **If Married:** How long_____ How many times_____	☐ Yes ☐ No	If yes, Who have you assigned Power of Attorney? _____ Relation to you? _____

Home Environment	Any relational stressors impacting your daily life?
How many people live with you? _____ Who lives in the home with you? _____ What town do you live in? _____	

SECTION 7: WORK HISTORY

Highest level of education	Currently working?	Present Occupation
	☐Yes - Full-time ☐ Yes - Part-time/PRN ☐No ☐Retired ☐Never worked	
Any history of learning difficulties?		
☐Yes ☐ No		

Disabled?	Former Occupation (if retired)
☐Yes ☐Applying for disability ☐No ☐On disability	

SECTION 8: LIFESTYLE HEALTH BEHAVIORS

Do you currently use tobacco?	☐ Yes ☐ No If yes, what type? How much each day?	Are you an ex-tobacco user?	☐ Yes ☐ No If yes, what type? When did you quit?
Do you currently drink alcoholic beverages? (Beer, wine or mixed drinks)	☐ Yes ☐ No	If so, How many drinks per day? ☐0 ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐ more than 6	
Did you drink alcoholic beverages in the past?	☐ Yes ☐ No Quit Date:	Has alcohol ever caused problems in your life? (For example: DUI, job or family problems) ☐ Yes ☐ No	
Do you have a history of prescription medication or illegal substance use?	☐ Yes ☐ No Type: Quit Date:	Current use? ☐ Yes ☐ No If yes, what type and how long?	
Do you exercise?	☐ Yes ☐ No If yes, how many times per week?		

SECTION 9: FAMILY MEDICAL HISTORY (BLOOD RELATIVES ONLY)

	Age	Age at death	Significant health problems or cause of death
Birth Father			
Birth Mother			

Do you have any brothers?	☐ Yes ☐ No If yes, How many living? _____ How many have died? _____	Please list any medical problems they have (and if not living, the cause of death):
Do you have any sisters?	☐ Yes ☐ No If yes, How many living? _____ How many have died? _____	Please list any medical problems they have (and if not living, the cause of death):
Do you have any biological children?	☐ Yes ☐ No If yes, How many living? _____ How many have died? _____	Please list any medical problems they have (and if not living, the cause of death):

SECTION 10: REVIEW OF SYSTEMS

Please mark each box for any CURRENT problems you are having (NOT IN THE PAST).

System 1: Neurological	System 2: General
☐NO PROBLEMS	☐NO PROBLEMS
☐ Headaches ☐ Seizures or convulsions ☐ Tremors ☐ Weakness in arms or legs ☐ Dizziness or vertigo ☐ Fainting or passing out ☐ Numbness or tingling ☐ Problems with memory	☐ Fever, chills or sweats ☐ Insomnia/difficulty sleeping ☐ Recent weight gain over 10 pounds ☐ Unexplained weight loss ☐ Decreased appetite ☐ Fatigue
System 3: Ear/Nose/Mouth/Throat	**System 4: Cardiovascular**
☐NO PROBLEMS	☐NO PROBLEMS
☐ Ringing in the ears ☐ Decreased hearing ☐ Hearing aid(s) ☐ Sinus congestion ☐ Sore throat/pain when swallowing ☐ Choking on food/liquids ☐ Swollen glands in neck ☐ Frequent nose bleeds ☐ Mouth sore	☐Chest pain ☐Irregular heartbeat or heart racing ☐Heart murmur ☐Sudden shortness of breath at night while laying ☐Shortness of breath with exertion ☐Fainting spells ☐Leg edema ☐Rapid heart beat ☐Pain/cramps in lower legs
System 5: Gastrointestinal	**System 6: Respiratory**
☐NO PROBLEMS	☐NO PROBLEMS
☐Nausea/vomiting ☐Diarrhea ☐Bloody or black stools ☐Heartburn or reflex ☐Constipation ☐Change in bowel patterns ☐Stomach pain ☐Belching	☐Shortness of breath ☐Chronic cough ☐Coughing up blood ☐Wheezing ☐CPAP/BIPAP
System 7: Eyes	**System 8: Musculoskeletal**
☐NO PROBLEMS	☐NO PROBLEMS
☐Blurred vision ☐Double vision ☐Loss of vision ☐Eye pain	☐Joint pain – arthralgia ☐Muscle cramping ☐Muscle stiffness ☐Swollen joints ☐Muscle weakness

System 9: Skin	System 10: Allergies
☐NO PROBLEMS	☐NO PROBLEMS
☐Dry skin ☐Loss of hair ☐Rash ☐Moles change in size/color	☐Hives ☐Tongue swelling ☐Hay fever ☐Itchy eyes ☐Seasonal allergies
System 11: Psychological	**System 12: Endocrine**
☐NO PROBLEMS	☐NO PROBLEMS
☐ Mood swings ☐ Feeling sad/depressed ☐ Panic attacks ☐ Abnormal sleep patterns ☐ Suicidal or homicidal thoughts ☐ Anxiety ☐ Hallucinations (seeing or hearing things that other people do not see or hear)	☐ Excessive thirst ☐ Excessive urination ☐ Increased facial hair in women ☐ Cold or heat intolerance ☐ Change in hat or glove size
System 13: Lymphatic	**System 14: Genitourinary**
☐NO PROBLEMS	☐NO PROBLEMS
☐ Excessive bruising or bleeding ☐ Swollen glands in neck, armpits or groin	☐Painful urination ☐Excessive urination (day or night) ☐Bloody urine **WOMEN:** ☐ Irregular periods ☐ Vaginal discharge ☐ Abnormal menstrual flow ☐ Nipple discharge **MEN:** ☐Discharge from penis ☐Incontinence ☐Erectile dysfunction ☐ Swelling in scrotum ☐ Urinary urgency ☐Difficulty starting a urination stream

15. Please write any other problems you may be having in the space below: