ATLANTA NEUROLOGY, P.C.

New Patient Consultation Form

Name: _____ Date: _____
Referring Physician: _____ Primary Physician: _____
Your Age: _____ DOB: _____ Handedness: ☐ Right ☐ Left
Marital Status: _____ Occupation: _____
E-mail Address: _____ Telephone Number: _____
Pharmacy Name: _____ Pharmacy Telephone Number: _____

Tobacco Use: ☐ Never ☐ Former ☐ Current - How much? _____
Alcohol Use: ☐ Never ☐ Former ☐ Current - How much? _____

Chief Complaint/Why were you referred to us? _____

_____

Describe this problem (emphasize when, where, how often, how long, how severe, and what helps or worsens it): _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Past Medical History: Mark any illness(es) you may have had or currently have:

☐ Acid Reflux/GERD
☐ ADD/ADHD
☐ Alcohol Abuse
☐ Anxiety
☐ Asthma/Lung Disease
☐ Atrial Fibrillation
☐ Autoimmune Disease
☐ Brain Tumor
☐ Cancer, Type _____
☐ Depression
☐ Dementia
☐ Diabetes
☐ Drug Abuse
☐ Epilepsy/Seizure
☐ Fibromyalgia
☐ Glaucoma
☐ Head Injury
☐ Headaches
☐ Heart Disease
☐ High Cholesterol
☐ HIV
☐ Hypertension
☐ Insomnia
☐ Kidney Stones
☐ Meningitis
☐ Muscle Disease
☐ Neck/Spinal Injury
☐ Nerve Injury
☐ Sleep Apnea
☐ Stroke
☐ Thyroid Disease
☐ Ulcers/GI Bleeding
☐ Other: _____

Please elaborate if needed: _____
_____
_____
_____
_____

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Medications: List all current medications. Name of medication, dosage, and frequency taken.

Medication Name	Dosage	Frequency	Medication Name	Dosage	Frequency

Drug Allergies: □ None □ Medication(s) name, type of reaction(s):

_____

_____

Surgeries and/or Hospitalizations:

_____

Family Medical History: Has anyone in your family ever had the following disease(s)? *List which family member.*

□ ALS
□ ADD/ADHD
□ Brain Aneurysm
□ Brain Bleed/Hemorrhage
□ Brain Tumor
□ Cancer, Type _____
□ Dementia (Alzheimer's)
□ Depression/Anxiety
□ Diabetes
□ Dystonia/Tics
□ Epilepsy/Seizure
□ Headaches/Migraines
□ Heart Disease
□ Movement Disorder
□ Multiple Sclerosis
□ Neuropathy
□ Parkinson's Disease
□ Stroke
□ Substance Abuse
□ Tremor
□ Other: _____

Review of Symptoms: *Mark any symptoms you are currently experiencing.* **Height: _____Weight: _____**

Constitutional:	Respiratory:	Neurological:
□ Daytime sleepiness □ Fever □ Insomnia □ Snoring □ Weight gain □ Weight loss	□ Cough □ Shortness of breath	□ Difficulty swallowing □ Falls □ Headache □ Memory trouble □ Numbness □ Slurred speech
Skin:	Gastrointestinal:	Psychological:
□ Rash	□ Appetite change □ Bloody stool	□ Anxiety □ Depression
HENT:	Genitourinary:	Hematological:
□ Dizziness/vertigo □ Double vision □ Ringing in ear(s) □ Vision loss	□ Bladder incontinence □ Loss of sexual interest	□ Excessive bruising □ Swollen lymph nodes/glands
Cardiovascular:	Musculoskeletal:	Women's Health:
□ Chest pain □ Fainting □ Palpitations	□ Muscle pain □ Painful or swollen joints □ Weakness	Breastfeeding? □ Yes □ No Pregnant? □ Yes □ No Using birth control? □ Yes □ No