ATLANTA NEUROLOGY
PATIENT INFORMATION

Name:_____ Date: _____
Referring Physician: _____ Primary Physician: _____
Your Age: _____ Handedness: R L Date of Birth: _____
Marital Status: _____ Occupation: _____
E-MAIL ADDRESS:_____
PHONE: (Home)_____ (Work)_____

TOBACCO USE: ☐NEVER? ☐FORMER? ☐CURRENT? **HOW MUCH? _____**	**ALCOHOL USE: ☐NEVER? ☐FORMER? ☐CURRENT?** **HOW MUCH? _____**

Why were you referred to us (what is your chief complaint)? _____
_____

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

PAST MEDICAL HISTORY

Please mark any illness you may have had:

	Headache		Meningitis		High Blood Pressure		Diabetes
	Sleep Disorder		Head Injury		High Cholesterol		Cancer
	Epilepsy/Seizure		Neck/Spinal Injury		Thyroid Disease		HIV
	Brain Tumor		Nerve Injury		Kidney Stones		Alcohol Abuse
	Stroke		Muscle Disease		Glaucoma		Drug Abuse
	Depression/Mental Illness		Heart Disease		Lung Disease/Asthma		Any Other Medical Problems? _____
			Atrial Fibrillation		Ulcers/GI Bleeding		

Please describe any marked illnesses: _____
_____
_____
_____

[Please Also Complete Reverse Side]

Your Name:_____ Date: _____

PHARMACY NAME:_____ PHONE #:_____

MEDICATIONS

Pill Name:	Pill Dose (mg)	How Often?	Pill Name:	Pill Dose (mg)	How Often?

DRUG ALLERGIES

Name of Drug	Type of Reaction

SURGERIES OR HOSPITALIZATIONS?

FAMILY HISTORY

Has anyone in your family ever had:	Yes	No	Relationship
Alzheimer's Disease (dementia)			
Stroke			
Dystonia/Tics			
Mental Illness (depression, substance abuse, etc)			
Parkinson Disease			
Brain Aneurysm (brain bleeding)			
Brain tumor			
Epilepsy			
Migraine			
Other: _____			

REVIEW OF SYSTEMS

WHAT IS YOUR CURRENT HEIGHT ___FT ___IN, AND WEIGHT _____LBS

MARK ANY SYMPTOMS YOU CURRENTLY HAVE:

Constitutional:
_____ Weight Loss over 5#
_____ Weight Gain over 5#
_____ Fevers
_____ Daytime Sleepiness
_____ Snoring
_____ Insominia

Skin:
_____ Rash

ENT:
_____ Headaches
_____ Vertigo
_____ Double Vision
_____ Visual Loss

Cardiovascular:
_____ Chest Pain
_____ Fainting
_____ Palpitations

Respiratory:
_____ Cough
_____ Shortness of Breath

Gastrointestinal:
_____ Appetite Change
_____ Bloody or Dark Stools

Genitourinary:
_____ Urinary Incontinence
_____ Loss of Sexual Interest

Musculoskeletal:
_____ Muscle Pain
_____ Weakness

Neuro/Psych:
_____ Memory Trouble
_____ Anxiety/Depression
_____ Numbness
_____ Slurred Speech
_____ Difficulty Swallowing

Heme/Endocrine:
_____ Swollen Lymph Nodes
_____ Swollen Glands

Other (explain):

For Women: Are you pregnant? Y N Do you use birth control? Y N Are you nursing? Y N
(Inform the office if you become pregnant!)