

**ASSOCIATED NEUROLOGICAL SPECIALTIES**

**AUSTIN EMG      CAPITOL EEG**

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**PATIENT- PLEASE FILL OUT INFORMATION BELOW**

This information will assist us in your treatment. If you have difficulty answering these questions, please speak with a member of our staff at the time of your visit.

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_ Age: \_\_\_\_\_

Referred by: \_\_\_\_\_ MD Dr.'s Phone: \_\_\_\_\_

1. What is the reason for this visit?

\_\_\_\_\_

Chief concern/ symptoms: \_\_\_\_\_

2. When did you first become aware of this problem? \_\_\_\_\_

3. Describe the duration and course of the problem (continuous, intermittent, etc.) \_\_\_\_\_

\_\_\_\_\_

4. What part of the body is most affected? \_\_\_\_\_

5. Describe this problem: \_\_\_\_\_

6. Have you noticed other changes in bodily function, which developed around the time of your present problem (Y/N)? If so, please specify: \_\_\_\_\_

7. Is there anything that makes your problem better (medications, rest, etc.)? \_\_\_\_\_

8. Is there anything that makes your problems worse (exercise, lack of sleep, certain foods, etc.)?

\_\_\_\_\_

9. Have you previously received a diagnosis for this problem? (Y/N) \_\_\_\_\_

If so, please specify: \_\_\_\_\_

10. Have you received treatment for this problem? (Y/N) \_\_\_\_\_

If so, please specify what treatment and when: \_\_\_\_\_

11. If you answered "Yes" to questions 9 and/or 10, please provide the attending physician's name and address: \_\_\_\_\_

12. Has your problem interfered with your activities of daily living (bathing, feeding, or clothing yourself)? \_\_\_\_\_

13. Has your problem interfered with your occupation? \_\_\_\_\_

14. Does anyone in your family have a similar problem? \_\_\_\_\_

15. Is anyone in your family known to have a neurological disease (Y/N)? \_\_\_\_\_

If so, please specify: \_\_\_\_\_

**Please check the appropriate answers and/or conditions**

**General Health**                     Excellent     Good     Fair     Poor

**Childhood Diseases**             Chicken Pox     Heart Disease     Rheumatic Fever  
 Measles             Scarlet Fever     Mumps     Seizures  
 Other: \_\_\_\_\_

**Adult Illnesses**             Anemia (Low blood)             Asthma             Bleeding tendencies  
 Blood clotting disorder             Bronchitis  
 Cancer, Identify Type: \_\_\_\_\_  
 Diabetes                             Emphysema             Heart Disease  
 Hypertension (high blood pressure)     Bladder Disease             Glaucoma  
 Gallbladder Disease             Influenza             Tuberculosis  
 Hepatitis (liver infection)             Thyroid Disease  
 Jaundice (yellow skin)             Kidney disease or stones  
 Skin lesions or rashes  
 Autoimmune Disorder, Identify Type: \_\_\_\_\_  
 Arthritis, Identify Type: \_\_\_\_\_  
 Other: \_\_\_\_\_

**If you have checked one of the above, please explain:** \_\_\_\_\_

**Describe the illness (i.e. when, where, nature of illness):** \_\_\_\_\_

**Treatment? Resolution:** \_\_\_\_\_

**Sexually Transmitted Disease:** \_\_\_\_\_

Please Identify which type of disease: \_\_\_\_\_

**Mental Illness**             Depression             Bipolar Disorder     Dysthymic Disorder             Suicide  
 Panic Disorder             Generalized Anxiety Disorder             Schizophrenia  
 Obsessive-Compulsive Disorder             Post-Traumatic Stress Disorder  
 Social Phobia             Agoraphobia             Specific Phobia  
 Other: \_\_\_\_\_

**Current Weight:** \_\_\_\_\_

**Operations/ Hospitalizations.** List dates and diagnoses: \_\_\_\_\_

**Accidents/ Injuries.** List dates and types of injuries: \_\_\_\_\_

**Implants.** List any implants that you have had (breast, penile, eye, etc.) \_\_\_\_\_

**Please check any of the following statements and/or symptoms, which apply to you:**

**General:**  Good Health most of the time  Ill occasionally  Frequently Ill  
 Easily fatigued  Fatigued only after exercise  Fatigued upon awakening  
 Fatigued all the time  Excessive weight gain  
 Excessive weight loss (Specify  lbs in  days)

**Skin:** Change in :  Color  Moisture  Texture (dry or oily)  
Do you have:  Lesions  Masses  Easy bruising  
 Bleeding  Itching  Scaling

**Hair:** Do you have:  Loss  Excessive growth  Change in Texture or Distribution

**Glands:**  Enlargement  Pain  Drainage

**Blood:**  Leukemia  Anemia (Low Blood)  Bleeding Disorders

Other: \_\_\_\_\_

**Endocrine:**  Abnormal Growth or body configuration, excessive-sweating, unusual sensitivity or insensitivity to hot or cold  
 Increased thirst, urination, or hunger?  
 Infertility or any known hormonal abnormality?  
 Any known thyroid problem (goiter, exophthalmos)

**Head:**  Trauma

**Eyes:**  Loss of vision  Trauma  Color Blindness  
 Infection  Retinopathy  Retinal Detachment

**Nose:**  Trauma  Runny Nose  Nose bleeds  
 Frequent nasal/ sinus infection

**Mouth:**  Trauma  Difficulty Chewing  Pain  
 Infection  Excessive Tongue Movement  Excessive Salivation

**Throat:**  Hoarseness  Trauma  Frequent Sore Throat  
 Change in voice  Pain or Difficulty swallowing

**Neck:**  Swallowing  Stiffness  Weakness  
 Pain  Trauma  Limitation of movement

**Breasts:**  Change in size  Lumps  Nipple discharge  
 Skin lesions  Change in color

**Respiratory:**  Wheezing  Coughing  Asthma  
 Tuberculosis  Night Sweats  Sputum production (Coughing up mucus)  
 Shortness of breath at rest  Shortness of breath after walking  blocks  
 Other lung infection

**Cardiovascular:**  Angina (chest pain)  Irregular heart rate/ rhythm  Palpitations  
 High blood pressure  Pain in legs after walking  Cold hands and/or feet  
 Shortness of breath after exercise  Swelling of hands and/ or feet  
 Shortness of breath at night before falling asleep  
 Shortness of breath at night, which awakens you from, sleep

**Gastrointestinal:**  Nausea  Belching  Vomiting  
 Vomiting Blood  Abdomen Pain  Change in appetite  
 Change in bowel habits  Change in bowel movements  Gas  
 Jaundice (Yellow Skin)  Difficult or painful urination

**Genitourinary**     Change on color of urine     Increased urination     Decreased urination  
 Difficult or painful urination     Frequent urination at night     Change in menstrual cycle

**Allergies**     Pollen     Dust     Medications, specify:

**Neurological**    Disturbances of:     Smell     Vision     Double Vision  
 Excessive Eye Movement     Decreased facial sensation     Difficulty Chewing

Difficulty with:     Speech     Swallowing     Taste  
 Hearing     Balance     Neck Movement

Generalized weakness of muscles, specify:

Sensation of heavy eyelids

Muscle paralysis (inability to move any particular muscle, specify:

Decrease in muscle size, specify where:

Decrease in muscle strength, specify where:

Involuntary movements (uncontrollable shaking, twitching, or spasms in muscles)

Decreased or increased sense of touch     Loss of sensation

Shooting pain     Numbness

Muscle pain, swelling, or tenderness, specify where:

Easy muscle fatigability on exercise

Alternating diarrhea and constipation

Inability to control urine or bowels

Excessive sweating     Decreased sweating

Uncontrollable or inappropriate crying or laughing

Impotence (inability to have or sustain an erection)

Memory loss     Difficulty concentrating     Depression     Mood swings

Difficulties with sleep:  Excessive sleeping (hypersomnolence)     Inability to sleep (insomnia)

Blackouts     Fainting spells     Dizziness

Seizure(s)     Headaches     Light-headedness

Low Back Pain:

With radiation to leg (s)     Without radiation to leg(s)

Neck Pain

With radiation to arm(s)     Without radiation to arm(s)

Habits	Present	Past	How Much
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**Tobacco** (including smokeless varieties like snuff, chewing tobacco, etc.)

Y/N     Y/N     /Day

**Alcohol**     Y/N     Y/N     /Day

**Exercise**     Y/N     Y/N     /Week

**Drug Use**     Y/N     Y/N     /Day

**Hobbies:** \_\_\_\_\_



Are you currently taking any herbal medicines or "health foods"? \_\_\_\_\_

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**Allergies.** List all allergies or unusual reactions to any medications. \_\_\_\_\_

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