

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
 Diabetes Emphysema Heart Disease
 Hypertension (high blood pressure) Bladder Disease Glaucoma
 Gallbladder Disease Influenza Tuberculosis
 Hepatitis (liver infection) Thyroid Disease Mental Illness
 Jaundice (yellow skin) Arthritis
 Kidney disease or stones Skin lesions or rashes
 Sexually transmitted disease 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
Tobacco (including smokeless varieties like snuff, chewing tobacco, etc.)	<input type="checkbox"/> Y/N	<input type="checkbox"/> Y/N	<input type="text"/> /Day
Alcohol	<input type="checkbox"/> Y/N	<input type="checkbox"/> Y/N	<input type="text"/> /Day
Exercise	<input type="checkbox"/> Y/N	<input type="checkbox"/> Y/N	<input type="text"/> /Week
Drug Use	<input type="checkbox"/> Y/N	<input type="checkbox"/> Y/N	<input type="text"/> /Day

Hobbies: _____

Family History: Please check if anyone in your family now has or has ever had any of the following conditions:

Diabetes High Blood Pressure Heart Problems Asthma
 Kidney Disease Thyroid Disease Other:

Relationship of this family member to you: _____

Job History: List all occupations, past and present, and any possible exposure to potentially toxic chemicals or gases. _____

ADDITIONAL COMMENTS:

Please list all prescriptions and over- the-counter medications you are currently taking.

Be sure to bring all medication bottles with you to your office visit.

Date Started	Medication and Dosage	Refills	Side Effects	Date D/C'D

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

Allergies. List all allergies or unusual reactions to any medications. _____

