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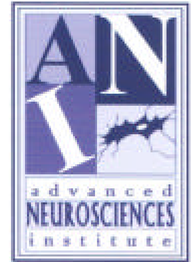
Advanced Neurosciences Institute
CURRENT MEDICAL INFORMATION
Neurology

Instructions: Complete the following information by checking the appropriate box or printing information.

Please do not write in the areas labeled "Reviewer's Comments."

Last name:
First name:
Date of Birth:
Social Security:



Current Medical Information

Please write in the box the problems you are now having:

Today's date:______________

Age:___ **Religion:**________ **Home Phone: (___)____-_______ Work Phone: (____)____-_______**

Do you have a living will, advance directives, or power of attorney for health care? ☐Yes ☐No

Did a physician send you? ☐Yes ☐No Name and address: ________________________________

Phone: **(___)___-____** ________________________________

I have received a copy of the Privacy Policy and am aware my private health care information may be available to insurers, government, and family members? ☐Yes ☐No

Signature of patient or legal guardian____________________________________

Name of person completing this form (if not patient):_________________________ Relationship:_________

Medications:

Identify **current** prescription *and* non-prescription medications. Include any vitamins, supplements, contraceptives, pain or cold medicines, as well as other remedies):

☐**No medicines now** ☐**See my attached list**

DO NOT WRITE ON REVERSE

Allergies:

Have you ever had a significant reaction to:

☐Latex ☐Rubber ☐Tape
☐Seafood ☐Iodine ☐Contrast Dye
☐Other:________________

Any medication allergy: ☐No ☐Yes (list below)

Name of Medication	Dose (mg)	Times per day taken	Medication Allergy	Describe reaction or allergy

Other recent medications:____

____

Have you taken cortisone, prednisone, or "steroid" type drugs in the last year? ☐No ☐Yes When?________

Have you taken aspirin or aspirin-containing medicines in the last two weeks? ☐No ☐Yes When?________

Are there medications "other than Allergies" which had unpleasant side effects?______________________

____

New Medical and Social Information

Any *new* or *worse* medical problems since your last visit:_____________________________________

____

____

Have you seen other doctors since your last visit? ☐No ☐Yes Whom, When and Why?___________

____

____

Have you started new medications since your last visit? ☐No ☐Yes Which ones and why?________

____

Have you had any significant events in your life since your last visit? ☐No ☐Yes

What & When?____

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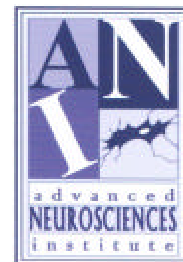

Review of Systems Please check "yes" or "no" to the following as related to your current visit.

Reviewer to elaborate where appropriate.

Have you had (please check item):	Yes	No	Reviewer's Comments
Any reactions to ☐foods, ☐molds, ☐dust or ☐bee stings?	☐	☐	Immune:
A ☐fever, ☐sore tongue, or ☐mouth sores in the last month?	☐	☐	Constitution:
A change in weight ☐up/☐down more than 10 lbs. in the last 6 mos?	☐	☐	
Any ☐enlarged glands, ☐goiter or ☐lymph nodes:	☐	☐	Heme:
☐blood clotting disorder, frequent bleeding ☐gums/☐nose or ☐bruising?	☐	☐	
A ☐skin rash, ☐sores, ☐breast lumps or ☐changing moles?	☐	☐	Integument:
Noticed a recent change in your ☐skin or ☐hair texture?	☐	☐	
Great difficulty with feeling ☐hot/☐cold when others are comfortable?	☐	☐	Endocrine:
Excessive ☐urination and ☐thirst? When?_____________________	☐	☐	
A problem with ☐disabling pain or ☐fatigue? Where?_____________	☐	☐	Musculoskel.:
☐Pain or ☐stiffness in your ☐joints (which:_______________) or ☐back?	☐	☐	
☐Double vision or ☐blurred vision? ☐Glasses? ☐Lazy or crossed eye?	☐	☐	Neuro:
Problems with ☐falling/☐staying asleep or being ☐too sleepy?	☐	☐	
☐Severe/☐frequent headaches? ☐Funny sensations or ☐numbness?	☐	☐	
☐Fainting, ☐falling, other ☐unusual spells, ☐seizures, or ☐convulsions?	☐	☐	
Difficulty with ☐slurred speech or ☐weak/☐clumsy ☐arm/☐leg?	☐	☐	
☐Tremors, ☐jerks, ☐cramps, or ☐other abnormal movements?	☐	☐	
Marked difficulty with ☐memory, ☐confusion, or ☐expressing yourself?	☐	☐	Psych:
Feel ☐stressed, ☐depressed, ☐tired, or ☐nervous frequently?	☐	☐	
Problem ☐hearing, ☐dizziness, ☐hoarseness or with ☐sinuses?	☐	☐	ENT:
Difficulty ☐eating, ☐drinking, ☐chewing, ☐choking or ☐swallowing?	☐	☐	
Chest ☐pain/☐pressure, abnormal ☐heart beat, ☐valve, or ☐murmur?	☐	☐	Vascular:
Shortness of breath ☐at night or ☐with only a little activity?	☐	☐	
Abnormal swelling of your ☐ankles or ☐feet? ☐Calf pain when walking?	☐	☐	
☐Asthma, ☐wheezing, or ☐coughing up ☐sputum or ☐blood?	☐	☐	Respiratory:
☐Indigestion, ☐heartburn, ☐nausea, ☐vomiting, or ☐stomach ulcers?	☐	☐	Gastrointestinal:
☐Constipation, ☐diarrhea, or ☐blood/☐changes in bowel movements?	☐	☐	
☐Burning or ☐pain when urinating or ☐bloody urine?	☐	☐	Urinary:
Difficulty with ☐starting urine, ☐emptying bladder, or ☐leaking urine?	☐	☐	
Difficulty with your sexual function?	☐	☐	
Women only:			Gyne:
A ☐mammogram, ☐Pap smear, and ☐pelvic examination in the last year?	☐	☐	
☐irregular menstrual periods or ☐recent abnormal vaginal discharge?	☐	☐	
Might you be pregnant at this time?	☐	☐	LMP:

Health Care Provider Review - I have reviewed this form with the patient:

Provider Signature	No.	Date	Provider Signature	No.	Date