Patient Identification Sticker

Welcome to the Steward SEMC Department of Neurology

How did you hear about us? (List the Physician's name/address/phone), website, or other referral source?

____

Who should receive correspondence regarding your care: (physicians, health providers)

[1] Name: ______________________ [2] Name: ______________________

Address: ______________________ Address: ______________________

______________________ ______________________

Phone: ______________________ Phone: ______________________

What is your neurological question or concern? ______________________________

____

Please list your **medical conditions and hospitalizations (include dates)**:

____

____

____

Please list all **major surgeries and procedures (include dates):**

____

____

What are your allergies? ______________________________

____

Has anyone in your family ever had a neurological condition or other medical problem?

Mother: ______________________________

Father: ______________________________

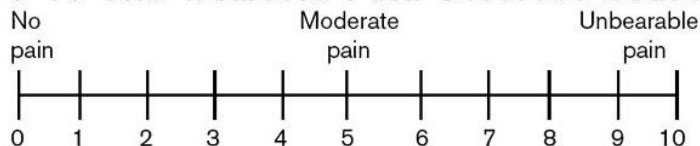
Siblings:______________________________

Other: ______________________________

Height:______________ Weight:______________

Are you experiencing pain today? Please circle Yes/No

If yes, please circle your level below:



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LIST CURRENT MEDICATIONS:

Drug Name	Dose	Frequency	Refills Needed?

REVIEW OF SYSTEMS: Please Circle YES or No

Neurological System

Do you have headaches? Y N
Do you have seizures? Y N
Have you ever lost consciousness? Y N
Do you have weakness? Y N
Do you have numbness? Y N
Do you have dizziness? Y N
Do you have double vision? Y N
Do you have blurred vision? Y N

Do you have confusion? Y N
Do you have memory loss? Y N
Do you have trouble walking? Y N
Do you have falls? Y N
Do you feel faint when standing? Y N
Do you have tremors? Y N

ENT

Any difficulties with hearing? Y N
Any loss of sense of smell? Y N
Any change in your voice? Y N

Mental Health

Do you feel depressed? Y N
Do you have sleeping problems? Y N
Do you feel anxious? Y N
Have you lost interest in your activities? Y N

Endocrine System

Do you have temperature changes? Y N
Are you thirsty frequently? Y N
Have you had weight changes? Y N

Cardiac System

Do you have chest pains? Y N
Do you have palpitations? Y N

Gastrointestinal System

Have you lost your appetite? Y N
Have you lost weight unexpectedly? Y N
Do you have indigestion or heartburn? Y N
Do you have stomach pains? Y N
Do you have constipation or diarrhea? Y N
Do you have nausea or vomiting? Y N
Do you have trouble swallowing? Y N

Urinary System

Do you have burning while urinating? Y N
Do you have blood in your urine? Y N
Do you wake up at night to urinate? Y N
Do you have urinary frequency? Y N
Do you lose control of bladder or bowels? Y N

Musculoskeletal System

Do you have neck pain? Y N
Do you have back pain? Y N
Do you have joint pains? Y N
Do you have any muscle pain? Y N

Skin

Do you have a rash? Y N
Do you have an abnormal mole? Y N

General

Do you have fevers? Y N
Do you have night sweats? Y N
Do you have fatigue? Y N

Do you have Advanced Directives? ________Do you have a Health Care Proxy? ________________________

Date:___________Time:________Patient Signature:____

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Social History: Please Circle Yes or No

Have you ever smoked? Y N
Do you smoke now? Y N
If yes, how many packs per day? ______________________________
For how long? ____
When did you quit? ____

Do you drink Alcohol? Y N
If yes, how many drinks per week?____________________________