St. Elizabeth's Medical Center
A STEWARD FAMILY HOSPITAL
Steward

Patient Identification Sticker

# Welcome to the Steward SEMC Department of Neurology

Name & Date of Birth_____

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

_____

_____

List your current or most bothersome problems or symptoms:

_____

_____

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

_____

_____

What are your allergies?

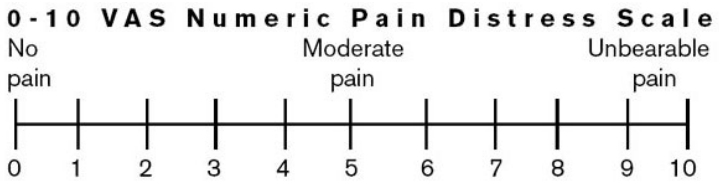
_____

_____

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? If yes, please circle your level below:




Do your medications wear "off" or stop working? (Circle one) Yes / No

If yes, on average how long does each dose last? _____ hours

**LIST CURRENT MEDICATIONS:**

| Drug Name | Dose | Frequency | Refills Needed? |
|---|---|---|---|
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**Circle any problems that you had in the past month related to each specific area:**

***Movement***

Tremor Stiffness Slowness Imbalance Walking Problems

Frequent Falling Movement Freezing Involuntary Movements

Muscle Spasm/Cramping

Other (Explain):_____

***Bowel or Bladder/Autonomic/Other***

Bladder Problems Constipation Diarrhea Chills/Sweats Fatigue

Leg Swelling Dizziness/Lightheadedness Fainting or Loss of Consciousness

Sexual Dysfunction

Other (Explain):_____

***Cognitive/Behavioral***

Anxiety Depression Apathy Sleep Problems Daytime Sleepiness

Fatigue Memory Loss Confusion Hallucinations

Paranoia Delusions Mania Impulsive Spending,

Sex or Gambling Executive Function Difficulties (planning, decision-making, etc.)

Sudden, Uncontrolled Sleep "Attacks"

Other (Explain):_____

***Speech/Swallowing/Gastrointestinal***

Speech Changes  Swallowing  Problems Drooling  Pneumonia  Weight Loss

Weight Gain  Aspiration  Nausea  Vomiting  Abdominal Pain

Facial Masking

Other (Explain):_____

***Other***

Fever  Chills  Hearing Loss  Headache  Joint Pain

Back Pain  Neck Pain  Palpitations  Chest Pain  Cough

Hearing Loss  Vision Change  Numbness/Tingling  Driving Challenges

***List any other concerns or problems that you have:*** _____

_____

_____

_____

**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? _____

Do you experience dyskinesia? (Circle one) Yes / No

Have you had any falls since your last visit? (Circle one) Yes / No

**List any changes in your living arrangements:**

_____

_____

_____

**Do you have Advanced Directives? _____**

**Do you have a Health Care Proxy? _____**

Date: _____Time:_____

Patient Signature: _____

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