Ravin Jain, MD

www.neurologychannel.com/jain

NEUROLOGY HISTORY

Please complete the questions below carefully before your scheduled appointment and bring the completed forms with you.

NAME: ____ **AGE**: _______**DATE:**___________

PRIMARY CARE PHYSICIAN: Name of the primary care physician who should receive the report of consultation:____

CHIEF COMPLAINTS(S): list the main problem(s) for which you are seeking neurology consultation (e.g. headache, pain, weakness, etc.):

PROBLEM	**DURATION**

DESCRIBE YOUR MAIN PROBLEM IN DETAIL:

Date of onset (approximate): ____

Duration:____

Progression:____

Location (e.g. right leg, front of head, etc.):____

Severity: ____

Frequency: ____

Other associated symptoms:____

Aggravating factors:____

COMMENTS:

NEUROLOGY HISTORY – PAGE TWO

CHECK WHICH SYMPTONS OR DISEASES YOU HAVE HAD:

	☑	ONSET
Headache	☐	
Blindness	☐	
Facial pain	☐	
Asymmetry of face	☐	
Ear pain	☐	
Ear discharge	☐	
Ringing in the ears	☐	
Deafness	☐	
Difficulty swallowing	☐	
Difficulty sucking	☐	
Difficulty chewing	☐	
Difficulty talking	☐	
Difficulty breathing	☐	
Chest pain/pressure	☐	
Palpitations	☐	
Nausea	☐	
Vomiting	☐	
Abdominal pain	☐	
Neck pain	☐	
Back pain	☐	
Tingling	☐	
Numbness	☐	
Burning feet	☐	
Weakness of arms	☐	
Weakness of legs	☐	
Fatigue	☐	
Weight loss	☐	
Thinning of muscles	☐	
Abnormal gait	☐	
Stiffness	☐	
Tremor/Abnormal movements	☐	
Memory loss	☐	
Confusion	☐	
Loss of consciousness	☐	
"Blackout" spells	☐	
Seizures (Epilepsy)	☐	
Syncope	☐	
Stroke (paralysis)	☐	
TIA or warning stroke	☐	
Urinary problems	☐	
Difficulty of bowel movements	☐	
Sexual dysfunction	☐	
Skin rashes	☐	
Join pains/swelling	☐	

NEUROLOGY HISTORY – PAGE THREE

CHECK WHICH SYMPTONS OR DISEASES YOU HAVE HAD:

	☑	ONSET
Sleep disturbances	☐	
Recurrent fever	☐	
Recurrent infections	☐	
High blood pressure	☐	
Diabetes	☐	
Heart disease	☐	
Kidney disease	☐	
Cancer	☐	
Surgery for:	☐	

SOCIAL HISTORY:
MARITAL STATUS: Married/Single/Divorced (circle one)
OCCUPATION: ____
ALCOHOL: ____
SMOKING:____
RECREATIONAL DRUGS: ____

FAMILY HISTORY:

	☑	ONSET
Hypertension	☐	
Diabetes	☐	
Kidney disease	☐	
Tuberculosis	☐	
Muscular dystrophy (MS)	☐	
Seizure disorder	☐	
Headache/migraine	☐	

LIST OF MEDICATIONS; (Include birth control pills, Aspirin, and over the counter medications):

NAME OF DRUG	DOSAGE	HOW OFTEN	DATE STARTED

ALLERGIES, IF ANY:

<u>**NEUROLOGY HISTORY – PAGE FOUR**</u>

HAVE YOU HAD A PRIOR NEUROLOGICAL EVALUATION; CT SCAN, MRI EXAM, EEG OR EMG? IF SO, GIVE REASON FOR EXAM IF KNOWN AND NAME OF THE PHYSICIAN:

____

____

____

____

____

IS THERE ANY OTHER PERTIENT INFORMATION YOU WOULD LIKE TO SHARE:

____

____

____

____

____

IF YOU HAVE ANY SPECIAL QUESTIONS OR CONCERNS, PLEASE USE THIS SPACE:

____

____

____

____

____

Thank you for taking time to fill out this history form. This will help me get to know you better and hopefully aid in you diagnosis and therapy.