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Adult Neurology Board Certified

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PATIENT MEDICAL INFORMATION FORM

Name: _____ Date of Birth: _____

Reason for seeing the doctor today (symptoms)

Please check each of the symptoms you are experiencing:

Constitutional:

☐ Weight gain ☐ Weight loss ☐ Fatigue ☐ Insomnia
☐ Poor memory ☐ Confusion ☐ Dizziness ☐ Fevers

Eyes: ☐ Double Vision ☐ Blurred Vision ☐ Visual Loss ☐ Dry Eyes ☐ Droopy Eyelids

Ears: ☐ Ringing in Ears ☐ Hearing Loss ☐ Fullness in Ears ☐ Vertigo

Throat: ☐ Dry Mouth ☐ Difficulty Chewing ☐ Painful Swallowing ☐ Difficulty Swallowing

GI: ☐ Nausea ☐ Vomiting ☐ Diarrhea ☐ Constipation

GU: ☐ Impotence ☐ Loss of Stool ☐ Loss of Urine ☐ Frequent Urination

Muscular:

☐ Back Pain ☐ Neck Pain ☐ Limb Pain ☐ Stiffness ☐ Spasms and Cramps

Neurological

☐ Headache ☐ Passing Out ☐ Weakness ☐ Shaking ☐ Twitching
☐ Poor Balance ☐ Falling ☐ Numbness ☐ Tingling ☐ Clumsiness

Do you smoke?: ☐ Yes ☐ No If yes, how many packs per day _____ for _____ years/months?
Do you drink alcohol?: ☐ Yes ☐ No If yes, what kind? _____ How much a week? _____
Are you? ☐ Right handed ☐ Left handed ☐ Both

FAMILY HISTORY	Medical Problem	Cause of Death	Age at Death
Mother			
Father			
Sibling 1:			
Sibling 2:			

Marital Status: ☐ Single ☐ Married ☐ Divorce ☐ Separated ☐ Widowed

Highest level of schooling completed:_____ Do you have children? ☐ Yes ☐ No

Referring Doctor: _____

Do you have a past history of any of the conditions listed below?

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Heart Attack	☐	☐	Liver Problems	☐	☐
High Blood Pres.	☐	☐	Heart Arrhythmia	☐	☐	Kidney Problems	☐	☐
Thyroid	☐	☐	Heart Valve Problem	☐	☐	Lung Problems	☐	☐
Stroke	☐	☐	Arthritis	☐	☐	Drug/Alcohol Abuse	☐	☐
Stomach Ulcers	☐	☐	Back Trouble	☐	☐	Mental Disease	☐	☐

Cancer: ☐ Yes ☐ No If yes, what type and treatment: _____

List any other medical illnesses not indicated above: _____

_____

_____

List surgeries: _____

_____

_____

Release of Medical Record and Assignment of Benefits:

I hereby authorize Susan P. Epner, M.D. to release my medical records to my insurance carrier or similar organization for verification of my medical claim(s). I hereby authorize my insurance benefits to be paid to Susan P. Epner, M.D.

_____ _____ _____

Print your name Signature Date

_____ _____

Reviewed by physician Date