

INFORMATION FOR YOUR PHYSICIAN

Pt # _____

TODAY'S DATE _____ PATIENT NAME _____

I. Chief Complaint

Please write the reason you came to the doctor at this time: _____

When did your symptoms begin? _____

Have you seen a neurologist previously? YES or NO

If yes, what is the neurologist's name? _____

Who is your primary care physician? _____

Who referred you to us? _____

Are you seeing us today about a motor vehicle accident? YES or NO

Are you seeing us today about a workers compensation injury? YES or NO

If yes, what is the date of accident/injury? _____

II. Past Medical History

Please circle each illness or condition YOU have had.

- | | | |
|----------------------------|------------------------|-----------------------|
| AIDS | Heart attack | Mental illness |
| Asthma | Heart disease | Muscle/nerve disorder |
| Attention Deficit Disorder | Hepatitis | Neck Pain |
| Back Pain | HIV | Palpitations |
| Bleeding tendencies | High blood pressure | Pneumonia |
| Cancer | High cholesterol | Rheumatoid arthritis |
| Diabetes | Kidney disease | Shortness of breath |
| Glaucoma | Liver disease/jaundice | Stroke |
| Headache | Lupus | Syphilis |
| | | Thyroid disease |

Other _____

III. Surgical History.

Have you had surgery? YES or NO

If Yes, list surgery and year

1 _____

2 If Yes, list surgery and year

3 If Yes, list surgery and year

4 If Yes, list surgery and year

5 If Yes, list surgery and year

6 If Yes, list surgery and year

VII. Medications Please name or otherwise identify medicines now or recently used.

(Enter Medications from the "Summary Page, Patient Allergies".)

Medication		Strength (# mgs.)	Frequency (# times/day)
1 _____		_____	_____
Taking/using now?	YES or NO		
2 _____		_____	_____
Taking/using now?	YES or NO		
3 _____		_____	_____
Taking/using now?	YES or NO		
4 _____		_____	_____
Taking/using now?	YES or NO		
5 _____		_____	_____
Taking/using now?	YES or NO		
6 _____		_____	_____
Taking/using now?	YES or NO		
7 _____		_____	_____
Taking/using now?	YES or NO		
8 _____		_____	_____
Taking/using now?	YES or NO		
9 _____		_____	_____
Taking/using now?	YES or NO		
10 _____		_____	_____
Taking/using now?	YES or NO		
11 _____		_____	_____
Taking/using now?	YES or NO		
12 _____		_____	_____
Taking/using now?	YES or NO		

VIII. Allergies List medications or substances to which you have allergic reaction or sensitivity.

(Enter Allergies in "Summary Page, Patient Allergies.")

Please check box if there are no known medication allergies.

I am allergic to the following:

- 1 Medication/substance _____
Describe reaction _____
- 2 Medication/substance _____
Describe reaction _____
- 3 Medication/substance _____
Describe reaction _____
- 4 Medication/substance _____
Describe reaction _____
- 5 Medication/substance _____

Date _____ Patient Signature _____