WINCHESTER NEUROLOGICAL CONSULTANTS, INC.
125-A Medical Circle
Winchester, VA 22601
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PATIENT INFORMATION SHEET

Patient Name____ **Date**_______________________________

Date of Birth ____ **Age** _______________________________

Referring Doctor ____

Referring Doctor's Address ____

Referring Doctor's Phone # ____

Primary Care Physician/Family Physician ____

Primary Care Physician's Address ____

Primary Care Physician's Phone #____

Preferred Pharmacy ______________________________**Pharmacy Phone #**_______________________

To the Patient or Caregiver:
This information will be placed in the medical record. It is important to complete each section to the best of your ability and knowledge. If you are uncertain of dates, give approximate dates.

Chief Complaint: Please check all of those that apply to today's visit. Feel free to write in more if you need:

- ☐ Memory Impairment
- ☐ Headache
- ☐ Double Vision
- ☐ Vertigo
- ☐ Dizziness
- ☐ Syncope/Passed out
- ☐ Seizure/Epilepsy
- ☐ Muscle Weakness
- ☐ Weakness
- ☐ Muscle Pain
- ☐ Numbness
- ☐ Low back pain
- ☐ Neck pain

- ☐ Confusion
- ☐ Long-Term Memory Loss
- ☐ Short-Term Memory Loss
- ☐ Visual Loss
- ☐ Visual Disturbance
- ☐ Blurred Vision
- ☐ Tinnitus
- ☐ Noises in Ears
- ☐ Fainting
- ☐ Difficulty Speaking
- ☐ Difficulty Swallowing
- ☐ Leg Pain - ☐ right ☐ left
- ☐ Leg Numbness - ☐ right ☐ left
- ☐ Leg Weakness - ☐ right ☐ left

- ☐ Autism
- ☐ Developmental Delay
- ☐ Childhood Behavioral Disturbances
- ☐ Sleeping Difficulty
- ☐ Night Cramps
- ☐ Insomnia
- ☐ Jerking of Extremities

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Details: ____

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Allergies To Medications:

- ☐ No Known Drug Allergies
- ☐ Allergy History Unknown

- ☐ Acetaminophen
- ☐ Adhesive Tap
- ☐ Allergy History/Unknown
- ☐ Aminoglycosides
- ☐ Barbiturates
- ☐ Benzodiazepines
- ☐ Betadine
- ☐ Cephalosporins
- ☐ Codeine/Codeine Derivatives
- ☐ Epinephrine
- ☐ Erythromycin's
- ☐ Iodinated Contrast
- ☐ Latex

- ☐ Local Anesthetics(Amide-Procaine)
- ☐ Local Anesthetics(Ester – Lidocaine)
- ☐ Morphine Derivatives
- ☐ NSAIDS
- ☐ Penicillins
- ☐ Seafood
- ☐ Shellfish
- ☐ Sulfa Drugs
- ☐ Tetracycline's
- ☐ Vaccines - Albumin
- ☐ Other ____

Family History: Please list any significant medical or neurological conditions in your family, including those that are deceased (please give approximate age at time of death and cause of death).

Mother ____

Father ____

Brothers ____

Sisters ____

Children ____

Past Medical History: Please check all that apply to your medical history.

- □ Heart Disease
- □ Lung Disease
- □ Diabetes
- □ Blood Pressure
- □ Cancer
- □ Stroke
- □ Ulcers
- □ Hyperlipidemia (high cholesterol)
- □ Neck Pain
- □ Back Pain
- □ Encephalitis
- □ Meningitis
- □ Seizures
- □ Paralysis
- □ Memory Loss/Alzheimer's
- □ Major Trauma
- □ Anxiety
- □ Depression
- □ Bleeding Disorder
- □ Urinary/Bladder
- □ Thyroid
- □ Eye problems

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Details: ____

Social history::

Occupation: ____

Still in School? □ Yes

Retired? □ Yes

Marital Status: □ Married □ Widowed □ Divorced □ Separated □ Single □ Live-In

Do You Smoke? □ Yes □ No If yes, how much? ____________________

Do you drink alcohol? □ Yes □ No If yes, how much? ____________________

Do you use street drugs? □ Yes □ No If yes, what and how often? ____________

How many children do you have? Male: _______ Female: _______

Current Medications: (please include over-the-counter, non-prescription, and complementary medical treatments)

Name	Strength	Schedule
1) ____________________	____________________	____________________
2) ____________________	____________________	____________________
3) ____________________	____________________	____________________
4) ____________________	____________________	____________________
5) ____________________	____________________	____________________
6) ____________________	____________________	____________________
7) ____________________	____________________	____________________
8) ____________________	____________________	____________________
9) ____________________	____________________	____________________
10) ____________________	____________________	____________________

Review of Systems: To help us evaluate you the best, please check any symptoms which you have recently experienced, and add note, if applicable.

General
- ☐ Left handed
- ☐ Right handed
- ☐ Appetite loss
- ☐ Chills
- ☐ Dietary changes
- ☐ Fatigue
- ☐ Fever
- ☐ Medication change
- ☐ Night sweats
- ☐ Obesity
- ☐ Weight gain>10 lbs
- ☐ Weight gain<10 lbs.

Respiratory
- ☐ Falling asleep while driving a vehicle
- ☐ Snoring
- ☐ Shortness of breath
- ☐ Cough
- ☐ Decreased exercise tolerance
- ☐ Difficulty breathing
- ☐ Wheezing

Skin
- ☐ Bruising
- ☐ Clamminess
- ☐ Excessive sweating
- ☐ Hair growth
- ☐ Hair loss
- ☐ Hives
- ☐ Itching
- ☐ Nail changes
- ☐ New lesions
- ☐ Rash
- ☐ Skin color changes

HEENT
- ☐ Blurred vision
- ☐ Headache
- ☐ Head injury
- ☐ Double vision
- ☐ Visual disturbances
- ☐ Visual loss
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Ringing in ears
- ☐ Spinning sensation
- ☐ Seasonal Allergies

Cardiovascular
- ☐ Chest pain
- ☐ Difficulty breathing on exertion
- ☐ Fainting/Blacking out
- ☐ Edema
- ☐ Irregular heartbeat
- ☐ Abnormal blood pressure
- ☐ Elevated blood pressure
- ☐ Difficulty breathing while lying down
- ☐ Palpitations
- ☐ Rapid heart rate
- ☐ Leg pain and/or swelling
- ☐ Shortness of breath

Neck
- ☐ Neck mass
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Swollen glands

Neurological
- ☐ Numbness
- ☐ Auras
- ☐ Decreased memory
- ☐ Difficulty speaking
- ☐ Dizziness
- ☐ Dysesthesias/tingling
- ☐ Fainting
- ☐ Headaches
- ☐ Incontinence/stool
- ☐ Incontinence/urine
- ☐ Incoordination
- ☐ Loss of consciousness
- ☐ Seizures
- ☐ Spinning sensation
- ☐ Stroke
- ☐ Tremor
- ☐ Unsteadiness
- ☐ Visual changes
- ☐ Weakness

Musculoskeletal
- ☐ Neck Pain
- ☐ Left leg pain
- ☐ Left arm pain
- ☐ Right arm pain
- ☐ Right leg pain
- ☐ Back pain
- ☐ Muscle spasm
- ☐ Calf pain
- ☐ Joint pain
- ☐ Joint redness
- ☐ Joint stiffness
- ☐ Joint swelling
- ☐ Joint weakness
- ☐ Muscle atrophy
- ☐ Muscle cramps
- ☐ Muscle pain
- ☐ Muscle weakness

Endocrine
- ☐ Appetite changes
- ☐ Cold Intolerance
- ☐ Excessive thirst
- ☐ Excessive urination
- ☐ Hair changes
- ☐ Heat intolerance
- ☐ Hot flashes
- ☐ Sexual dysfunction
- ☐ Thyroid problem

Hematology
- ☐ Abnormal bleeding
- ☐ Anemia
- ☐ Blood clots
- ☐ Easy bruising
- ☐ Enlarged lymph nodes
- ☐ Nose bleed
- ☐ Pinpoint hemorrhage
- ☐ Prolonged bleeding

Behavioral/Other
- ☐ Irritability
- ☐ Loss of energy
- ☐ Decreased libido
- ☐ Loss of interest
- ☐ Spontaneous crying
- ☐ Suicidal thoughts
- ☐ Suicidal planning
- ☐ Anxiety
- ☐ Change in sleep pattern
- ☐ Delusions
- ☐ Depression
- ☐ Early awakening
- ☐ Fearful
- ☐ Hallucinations
- ☐ Hypersomnolence
- ☐ Inability to concentrate
- ☐ Mood changes
- ☐ Insomnia/poor sleep
- ☐ Panic attack

If you suffer from headaches, please answer the following:

1) On how many days in the last 3 months were your activities reduced by at least half because of your headaches? ______________ days

2) On a scale of 0-10, on average, how painful were these headaches? ______________
(0 = No pain at all, and 10 = pain as bad as it can be)

Diagnostic Studies: Please check all diagnostic studies you have had related to this visit.

Study	Date	Location
☐ MRI Brain	______________________	______________________
☐ MRI Spine	______________________	______________________
☐ CT Brain	______________________	______________________
☐ EMG/Nerve Study	______________________	______________________
☐ Myelogram	______________________	______________________
☐ Arteriogram	______________________	______________________
☐ EEG	______________________	______________________
☐ Other	______________________	______________________