Coastal Neurology
New Patient Questionnaire

Patient Name: _____
Date of Birth: _____ **Hand You Write With:** ☐ **L /** ☐ **R**

Why are you being seen today?

_____
_____
_____
_____

Please List CURRENT Medications with Dosages and Frequency

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

Please List Any Medication Allergies

_____ _____ _____ _____

Please List Current and Past Medical Problems and Prior Surgeries Including Dates and Side of Body Where Appropriate

High Blood Pressure	☐	Stroke	☐	Pacemaker	☐	Prostate Surgery	☐
Heart Bypass / Stent	☐	COPD	☐	Diabetes	☐	Knee Replacement	L / R
High Cholesterol	☐	Asthma	☐	Neck Surgery	☐	Hip Replacement	L / R
Low Back Surgery	☐	Cancer	☐	Heart Attack	☐	Other _____	
Atrial Fibrillation	☐	Hysterectomy	☐	Reflux	☐	_____	

What Medical Problems Run In Your Family?

High Blood Pressure	☐	Epilepsy	☐	Alzheimer's	☐	Heart Disease	☐
Diabetes	☐	Migraine	☐	Stroke	☐	Other _____	

Have You Ever Smoked? **Yes** ☐ **No** ☐

If Yes, How Many Packs Per Day? _____ **For How Long?** _____ **years**

How Much Alcohol Do You Drink Per Week? _____

Where you ever a Heavy Drinker? **Yes** ☐ **No** ☐

If you've Quit, How Long Ago? _____ **years**

Marital Status: **Single** ☐ **Married** ☐ **Separated** ☐ **Divorced** ☐ **Widowed** ☐

What is the Highest Level of School that You Completed? _____

Occupation: _____

Please List ALL Medical Problems, Hospitalizations, or Surgeries

_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you <u>currently</u> experiencing any of the following problems? (Check where appropriate)

	Yes	No		Yes	No
Headaches	☐	☐	**Visual Changes**	☐	☐
Dizziness	☐	☐	**Hearing Loss**	☐	☐
Vertigo	☐	☐	**Problems Swallowing**	☐	☐
Balance Problems	☐	☐	**Unexplained Weight Loss**	☐	☐
Memory Loss	☐	☐	**Fainting**	☐	☐
Attention Problems	☐	☐	**Liver Trouble**	☐	☐
Sleep Problems	☐	☐	**Kidney Trouble**	☐	☐
Numbness In Hands or Feet	☐	☐	**Bladder Incontinence**	☐	☐
Neck Pain	☐	☐	**Bowel Incontinence**	☐	☐
Back Pain	☐	☐	**Depression**	☐	☐
Are you Pregnant?	☐	☐	**Thoughts of Suicide**	☐	☐