



NEUROLOGY CONSULT

Please complete pages 1, 2 and top of 3 to "STOP HERE" line only.

Date: _____ Referring Doctor: _____ Ticket#: _____

Patient Name: _____ Date of Birth: _____

Age: _____ Height: _____ Weight: _____ Check Box: Right handed Left handed

Main Neurological Complaint: _____

Is this work related? Yes No

Is this accident related? Yes No

Current Medications you are taking (please include medication name, strength and how often you take it):

Do you take any herbal medications or supplements? If yes, please list:

Medical Illnesses: (Please circle all that apply)

- | | | |
|---------------------|------------------------------|--------------------|
| High Blood pressure | Heart attack | Bleeding disorders |
| Diabetes | Blockages in heart | Blood clots |
| High cholesterol | Congestive heart failure | Anemia |
| Headaches | Atrial fibrillation | Reflux |
| Stroke or TIA | Other irregular heart rhythm | Ulcers |
| Seizure | Heart valve | Cataracts |
| Tuberculosis | Kidney stones | Glaucoma |
| Asthma | Kidney dialysis | Thyroid |
| COPD | Kidney failure | under active |
| Pneumonia | Cancer: Type _____ | over active |
| Parkinson's | Alzheimer's | Sleep disorders |

Please list any other medical problems you have had

Surgeries: Have or ever had any of these surgeries (even as a child)?

- | | | |
|----------------|--------------------------|--------------------|
| Tonsils | Heart bypass | Neck surgery |
| Appendix | Heart stent/balloon | Back surgery |
| Gallbladder | Pacemaker | Hip (R, L, B) |
| Hysterectomy | Carotid Artery (R, L, B) | Knee (R, L, B) |
| C-Section | Kidney | Shoulder (R, L, B) |
| Tubal Ligation | Prostate | Brain surgery |
| Sinus | Carpal tunnel (R, L, B) | type _____ |
| Cataracts | Thyroid | |

Please list any other surgeries not mentioned above.

Allergies: Please list medication/other allergies (and reaction) None

Are you allergic to seafood? (Y / N) **Latex?** (Y / N) **Contrast Dye?** (Y / N)

Diet? Regular Low Salt Low cholesterol Diabetic Other _____

Family History:

Is there any family history of the following? If yes, please circle.

- | | | |
|------------------------|-------------------------|-------------|
| High blood pressure | Spine problems | Cancer |
| Diabetes | Alzheimer's | Migraines |
| Heart disease/problems | Parkinson's | Stroke |
| Multiple Sclerosis | Aneurysm (brain, other) | Brain tumor |

Please list any other family medical problems not mentioned above:

Social History:

Marital Status: Married Single Divorced Widowed
Number of children: _____ Employer: _____
Job description: _____ Level of education: _____
Do you smoke? Yes No If yes, how many packs per day? _____
Do you chew tobacco or smoke cigars? _____
Do you drink alcohol? If yes, how often? _____
Any illegal drug use (past/currently)? _____ Risk factors for HIV? _____

REVIEW OF SYSTEMS:	YES/NO	Cardiac System	YES/NO
Neurological System		Do you have chest pains?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a headache?	<input type="checkbox"/> <input type="checkbox"/>	Do you have palpitations?	<input type="checkbox"/> <input type="checkbox"/>
Do your headaches wake you up at night?	<input type="checkbox"/> <input type="checkbox"/>	Gastrointestinal System	
Do you have seizures?	<input type="checkbox"/> <input type="checkbox"/>	Have you lost your appetite?	<input type="checkbox"/> <input type="checkbox"/>
Have you ever lost consciousness for other reasons?	<input type="checkbox"/> <input type="checkbox"/>	Have you lost weight unexpectedly?	<input type="checkbox"/> <input type="checkbox"/>
Do you have weakness?	<input type="checkbox"/> <input type="checkbox"/>	Do you have indigestion or heartburn?	<input type="checkbox"/> <input type="checkbox"/>
Do you have numbness?	<input type="checkbox"/> <input type="checkbox"/>	Do you have stomach pains?	<input type="checkbox"/> <input type="checkbox"/>
Do you have dizziness?	<input type="checkbox"/> <input type="checkbox"/>	Do you have constipation or diarrhea?	<input type="checkbox"/> <input type="checkbox"/>
Do you have blurred vision?	<input type="checkbox"/> <input type="checkbox"/>	Do you have nausea or vomiting?	<input type="checkbox"/> <input type="checkbox"/>
Do you have confusion?	<input type="checkbox"/> <input type="checkbox"/>	Urinary System	
Do you have memory loss?	<input type="checkbox"/> <input type="checkbox"/>	Do you have burning while urinating?	<input type="checkbox"/> <input type="checkbox"/>
Do you have trouble walking?	<input type="checkbox"/> <input type="checkbox"/>	Do you have blood in your urine?	<input type="checkbox"/> <input type="checkbox"/>
Can you take care of yourself?	<input type="checkbox"/> <input type="checkbox"/>	Do you wake up at night to urinate?	<input type="checkbox"/> <input type="checkbox"/>
Do you fall?	<input type="checkbox"/> <input type="checkbox"/>	Do you lose control of urine or stool?	<input type="checkbox"/> <input type="checkbox"/>
Mental Health		Musculoskeletal System	
Do you feel depressed?	<input type="checkbox"/> <input type="checkbox"/>	Do you have neck pain?	<input type="checkbox"/> <input type="checkbox"/>
Do you have sleeping problems?	<input type="checkbox"/> <input type="checkbox"/>	Do you have back pain?	<input type="checkbox"/> <input type="checkbox"/>
Do you feel anxious?	<input type="checkbox"/> <input type="checkbox"/>	Do you have joint pains?	<input type="checkbox"/> <input type="checkbox"/>
Respiratory System		Where? _____	
Do you have a cough?	<input type="checkbox"/> <input type="checkbox"/>	General	
Do you cough up thick mucus?	<input type="checkbox"/> <input type="checkbox"/>	Do you have fevers?	<input type="checkbox"/> <input type="checkbox"/>
Have you coughed up blood?	<input type="checkbox"/> <input type="checkbox"/>	Do you have night sweats?	<input type="checkbox"/> <input type="checkbox"/>
Do you have shortness of breath?	<input type="checkbox"/> <input type="checkbox"/>	Do you have fatigue?	<input type="checkbox"/> <input type="checkbox"/>
Skin		Do you have sore throat/sinus problems?	<input type="checkbox"/> <input type="checkbox"/>
Do you have a rash?	<input type="checkbox"/> <input type="checkbox"/>	Do you have frequent infections?	<input type="checkbox"/> <input type="checkbox"/>
		Do you have any bleeding or easy bruising?	<input type="checkbox"/> <input type="checkbox"/>

Date: _____ Time: _____ Patient Signature: _____
Date: _____ Time: _____ Physician Signature: _____

STOP HERE

(For Physician use only)
Impression: _____

Recommendations: _____

NEUROLOGICAL AND PHYSICAL EXAM:

General: BP: lying _____ sitting _____ standing _____
Pulse _____ Weight _____ Height _____ Resp _____ Temp _____

Normal Dictated

_____ General Appearance: _____

_____ Mental Status (brief): _____

_____ Cranial Nerves (including pupils): _____

_____ Cranial Nerves (excluding pupils, see below):

The **R L Both** pupils reveal abnormalities because of the presence of prior surgery.

_____ Motor Exam: _____

_____ Sensory Exam: a) pin b) light touch c) vibratory d) proprioception in upper extremities

a) pin b) light touch c) vibratory d) proprioception in lower extremities

_____ Reflexes: +1 +2 +3 and symmetrical in the upper extremities

+1 +2 +3 and symmetrical in the lower extremities

_____ Plantar responses: Flexor _____ Extensor on the R L B

Flexor on the R L _____ Neither _____ No Clonus

_____ Coordination: Heel to shin: _____

Finger - nose - finger: _____

Rapid Alternating Movements: _____ UE _____ LE

_____ GAIT: _____

Tandem: _____

_____ HEENT: _____

_____ Carotid exam: _____

_____ Cardiac exam: Presence of _____ /6 systolic ejection murmur

_____ Lungs: _____

_____ Abdomen: _____

_____ Skin: _____

_____ Extremities: _____

MUSCULOSKELETAL EXAM:

_____ Neck (mobility, inspection): _____

_____ Back (mobility, inspection): _____

_____ Tinel's and Phalen's Signs at the wrists: _____

_____ Tinel's at the elbows: _____

_____ SLR: _____

_____ HIPS: _____

OTHER COMMENTS:

