NEURO-ONCOLOGY Associates

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Today's Date: _____

Patient Name:_____ Age:____ Date of Birth:_____

Main Reason for Visit:_____

Height:_____ Weight:_____ ◯ Right Handed or ◯ Left Handed

Referring Physician: _____ Phone #: _____ City: _____

Primary Care Physician: _____ Phone #: _____ City: _____

◯ Please send copies of clinic notes to these physicians. ◯ DO NOT send copies of clinic notes to any other physicians.
Please use the back page to list any other physicians who should receive copies.

When was your last MRI? _____ Where was the MRI performed? _____

Allergies to Medications (describe type of reaction or side effect): _____

_____

_____

PAST MEDICAL HISTORY:

Y	N	(Please choose one)
◯	◯	High blood pressure
◯	◯	Diabetes
◯	◯	High Cholesterol/Lipids
◯	◯	Thyroid Disease
◯	◯	Heart Disease
◯	◯	Cancer, Tumor, Malignancy
◯	◯	Stroke or TIA
◯	◯	Diagnosis of Epilepsy or Seizures
◯	◯	Treatment by Psychiatrist or Counselor

Other: _____
Other: _____

PAST SURGERIES:

Y	N	(Please choose one)
◯	◯	Brain surgery: Tumor type _____
◯	◯	Neck or back surgery (circle)
◯	◯	Sinus, facial or dental surgery (circle)
◯	◯	Vascular surgery
◯	◯	Heart or lung surgery (circle)
◯	◯	Abdominal surgery
◯	◯	Hysterectomy, tubal ligation, C-section (circle)

Other: _____

INJURIES:

Y	N	(Please choose one)
◯	◯	Head injury
◯	◯	Spinal injury
◯	◯	Hand, leg, arm or foot injury (circle)

Other injuries, fractures: _____

Current Medications (Drug)	Dose	Frequency (times taken per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY:

Family Member	Check Box if Alive	Age (Current or at Time of Death)	Health Status or Cause of Death
Grandmother (Mom's)	☐		
Grandfather (Mom's)	☐		
Grandmother (Dad's)	☐		
Grandfather (Dad's)	☐		
Mother	☐		
Father	☐		
Sister/Brother (circle one)	☐		
Sister/Brother (circle one)	☐		

Is there a history of the following in your family? If so, please list family member(s):

Y	N	(Please choose one)	Y	N	(Please choose one)
○	○	Alzheimers _____	○	○	Hypertension _____
○	○	Brain Tumor _____	○	○	Migraine Headaches _____
○	○	Cancer _____	○	○	Multiple Sclerosis _____
○	○	Cerebral Palsy _____	○	○	Neurofibromatosis _____
○	○	Diabetes _____	○	○	Stroke _____
○	○	Epilepsy _____	○	○	Tremors _____
○	○	Heart Disease _____	○	○	Tuberous Sclerosis _____

OTHER HISTORY:

Occupation: _____ Retired (year): _____

Work Status: ☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled: Short-term/Long-term

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you have children: ☐ No ☐ Yes How many? _____

Who lives with you at home? _____

Tobacco Use: ☐ Never ☐ Yes (see below) ☐ Quit (see below)

Start (year): _____ Quit (year): _____

Type: ☐ Cigarette: Packs per day _____ ☐ Pipe ☐ Snuff ☐ Cigar ☐ Chew

Do you drink alcohol? ☐ No ☐ Yes How Much? _____

Do you exercise regularly? ☐ No ☐ Yes Times per week: _____ Type: _____

Have you been exposed to HIV? ☐ Don't know ☐ No ☐ Yes

Have you ever received a blood transfusion? ☐ No ☐ Yes Date of transfusion: _____

Have you been exposed to toxins? ☐ Don't know ☐ No ☐ Yes Type: _____

REVIEW OF SYSTEMS: Have you experienced the following symptoms during the last year?

Please choose yes or no for each response.

Constitutional	Y	N
Fever (constant)	○	○
Weight Loss	○	○
Weight Gain	○	○
Blackouts	○	○
Dizziness	○	○
Excessive Fatigue	○	○
Poor Appetite	○	○
Hot Flashes	○	○
Chills	○	○
Night Sweats	○	○

Other: _____

Gastrointestinal	Y	N
Indigestion – Pain w/Eating	○	○
Choking on Food	○	○
Diarrhea	○	○
Nausea	○	○
Heartburn	○	○
Constipation	○	○
Vomiting	○	○
Blood in your Vomit	○	○
Abdominal Pain	○	○
Bowel Incontinence	○	○

Other: _____

Genitourinary	Y	N
Urinary Tract Infections	○	○
Painful Urination	○	○
Blood In Your Urine	○	○
Incontinence	○	○
Frequent Urination	○	○
Urination at Night	○	○
Decreased Urine Flow	○	○
Abnormal Periods	○	○
Vaginal Discharge	○	○

Other: _____

Musculoskeletal	Y	N
Muscle Weakness	○	○
Back Pain	○	○
Muscle Pain	○	○
Joint Stiffness	○	○
Joint Pain	○	○
Arthritis	○	○

Other: _____

Hematological/Lymphatic	Y	N
Anemia	○	○
Hemophilia	○	○
Swollen Glands	○	○
Sickle Cell Disease	○	○
Easy Bruising	○	○
Easy Bleeding	○	○

Other: _____

Neurological	Y	N
Seizures/Epilespsy	○	○
Problems with Memory	○	○
Disorientation / Confusion	○	○
Poor Balance	○	○
Speech Changes	○	○
Headaches	○	○
Tremors	○	○
Lack of Concentration	○	○
Double or Blurred Vision	○	○
Tingling	○	○
Paralysis	○	○
Numbness	○	○

Other: _____

Cardiovascular	Y	N
Chest Pain or Angina	○	○
Waking up Short of Breath	○	○
Short of Breath Lying Flat	○	○
Leg Swelling	○	○
Irregular Pulse	○	○
Heart Murmur	○	○
Heart Skipping	○	○
Heart Fluttering	○	○

Other: _____

Psychiatric	Y	N
Anxiety	○	○
Mood Swings	○	○
Hallucinations	○	○
Hyperactive	○	○
Irritable	○	○
Depression	○	○
High Stress	○	○

Other: _____

Allergy / Immunology	Y	N
Nasal Drainage	○	○
Frequent Infections	○	○
Allergy Shots	○	○
Autoimmune Disease	○	○
Seasonal Allergies	○	○
Frequent Colds	○	○

Other: _____

Endocrine	Y	N
Excessive Thirst	○	○
Heat Intolerance	○	○
Frequent Urination	○	○
Cold Intolerance	○	○
Increased Appetite	○	○
Diabetes	○	○
Thyroid Disease	○	○

Other: _____

Ear, Nose, Throat, & Mouth	Y	N
Wearing Hearing Aids	○	○
Hearing Loss	○	○
Balance Disturbance	○	○
Change in Smell	○	○
Sinus Pain	○	○
Sore Throat	○	○
Ringing Ears	○	○
Nasal Congestion	○	○
Nose Bleed	○	○
Hoarseness	○	○
Change in Taste	○	○
Ear Pain	○	○
Nasal Drainage	○	○

Other: _____

Skin/Breast	Y	N
Easy Bruising	○	○
Hair Loss	○	○
Nail Changes	○	○
Hives	○	○
Rash	○	○
Acne	○	○
Itching	○	○
Breast Lump	○	○
Nipple Discharge	○	○

Other: _____

Eyes/Head	Y	N
Glaucoma	○	○
Eye Pain	○	○
Vision Changes	○	○
Double Vision	○	○
Seeing Spots	○	○
Watery Eyes	○	○
Itchy Eyes	○	○
Headaches	○	○

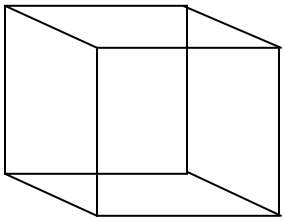
Other: _____

Respiratory	Y	N
Asthma	○	○
Chronic Cough	○	○
Chest Tightness	○	○
Emphysema	○	○
Shortness of breath - at rest	○	○
Shortness of breath - walking	○	○
Bronchitis	○	○
Pneumonia	○	○
Lung Cancer	○	○
Coughing Blood	○	○

Other: _____

PRE-EXAM EXERCISES: **(NEW PATIENTS: Please print this page off and complete the first three boxes)**

1. Please draw a copy of this cube in the space below:



2. Please draw a clock:

3. Please write a sentence here:

Current Medications (Drug)	Dose	Frequency (times taken per day)

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