Name: ____

Reason For Consultation:____

Primary Care: ____

Referring Physician: ____

Your Age: ________ Height: _______ Weight: ______

Past Medical History:

○ Diabetes	○ Brain tumor	○ Liver disease
○ High Blood Pressure	○ Brain Surgery	○ Injury to neck/back
○ Heart Disease	○ Cancer	○ Stomach ulcer/reflux
○ High Cholesterol	○ Sickle cell trait/disease	○ Thyroid disease
○ Heart Murmur	○ Bleeding disorder	○ Seizures/epilepsy
○ Heart Attack	○ Kidney or bladder infection	○ Tuberulosis
○ Mitral Valve Prolapse	○ Kidney stones	○ Stroke
○ Pacemaker	○ Polio	○ Meningitis
○ Rheumatic/Scarlet fever	○ Venereal disease	○ Blood Transfusion
○ Migraine or other headaches	○ Serious head injury	○ Other:
○ Asthma/Emphysema	○ Phlebitis	

List any operations you have had:

____

____

____

____

____

____

Name: ____ DOB: _________________

Please list ALL medications with their dosage (List all prescription, over the counter or herbal medications and birth control pills)

1.________________________________ 6. ________________________________

2.________________________________ 7._________________________________

3.________________________________ 8._________________________________

4.________________________________ 9._________________________________

5.________________________________10._________________________________

Are you allergic to any medications YES / NO

List all Allergies:

Medications	Reactions

Are you allergic to iodine, shellfish or X-ray contrast? ❑ YES ❑ NO

Women Only:

Are you pregnant now? ❑ YES ❑ NO

Last Menstrual Period? _____ / _______

Social History:

Caffeine Consumption : ❑ YES ❑ NO; Tea/Coffee/Cold drinks with caffeine

If Yes, No of cups per day: _______

What time of the day is your last cup of caffeine: ___________

Diet Sweeteners: ❑ YES ❑ NO

Cigarettes: ❑ YES ❑ NO

Name: ____ DOB: ____________________

If yes, No of packs per day: ____________

Age that you started smoking: __________

If past smoker, when did you quit smoking: ___________

If past smoker, how many years you smoked: ___________

Do you drink alcohol: YES / NO

If yes, how many drinks per day/week: _____________

What kind of drinks: _____________

Marital status: Single / Married / Widowed / Divorced / Seperated

Occupation: ____

Education Level: ____

Family Medical History:

	Alive	Age	Disease
Father	______	______	______________________________
Mother	______	______	______________________________
Brother(s)/Sister(s)	______	______	______________________________
	______	______	______________________________
Children	______	______	______________________________
	______	______	______________________________
	______	______	______________________________

Does anyone in your family have the following diseases?: (circle if applicable)

- ❑ Brain tumor
- ❑ Multiple Sclerosis
- ❑ Cancer
- ❑ Stroke
- ❑ Alzheimer’s disease
- ❑ other Neurologic disease
- ❑ Epilepsy
- ❑ Migraines
- ❑ ALS

Name: ____ DOB: ____________________

THE EPWORTH SLEEPINESS SCALE

How likely are to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

SITUATION CHANCE OF DOZING	**SCORE**
Sitting and reading	0 / 1 / 2 / 3
Watching TV	0 / 1 / 2 / 3
Sitting, inactive in a public place (e.g. a theatre or meeting)	0 / 1 / 2 / 3
As a passenger in a car for an hour without a break	0 / 1 / 2 / 3
Lying down to rest in the afternoon when circumstances permit	0 / 1 / 2 / 3
Sitting and talking to someone	0 / 1 / 2 / 3
Sitting quietly after a lunch without alcohol	0 / 1 / 2 / 3
In a car, while stopped for a few minutes in the traffic	0 / 1 / 2 / 3

<u>Sleep History:</u>

I have trouble sleeping at night:	❑ YES ❑ NO
I am sleepy all day	❑ YES ❑ NO
I have unwanted behaviors when I am sleeping	❑ YES ❑ NO
I have history of snoring	❑ YES ❑ NO
I have history of urge to move my legs at night	❑ YES ❑ NO
I am told that I kick my legs in sleep	❑ YES ❑ NO
I am told that I stop breathing in sleep	❑ YES ❑ NO

I usually go to bed at _________________

I usually wake up at _________________

Name: ____ DOB: __________________

Review of Systems:

General	Pulmonary	Musculoskeletal
○ Poor general health	○ Cough	○ Joint pain
○ Recent weight gain/loss	○ Coughing blood	○ Joint swelling
○ Fever	○ Coughing up phlegm	○ Injury to neck/back
○ Chills	○ History of TB	○ Neck pain
○ Night sweats	**Gastrointestinal**	○ Back pain
○ Fatigue	○ Abdominal pain	○ Muscle aches
○ Loss of appetite	○ Nausea/vomiting	○ Bone pain
Eye	○ Constipation	**Psychiatric**
○ Double vision	○ Diarrhea	○ Depression
○ Blurred vision	○ Impaired bowel control	○ Nervousness
○ Loss of vision	○ Vomiting blood	○ Anxiety
○ Eye pain	○ Blood in stool	**Sleep disorders**
○ Ear, Nose, Throat	○ Heartburn	○ Difficulty falling asleep
○ Hoarseness	**Genitourinary**	○ Difficulty staying asleep
○ Abnormal/Loss of taste	○ Frequent urination	○ Snoring
○ Difficulty swallowing	○ Urgency	○ Vivid dreams
○ Slurred Speech	○ Prostate problems	○ Sleep talking/walking
○ Ringing in the ears	○ Impaired bladder control	○ Acting out dreams
○ Loss of hearing	○ Blood in urine	**Endocrine**
○ Sinus problems	○ Bladder or urinary pain	○ Heat or cold intolerance
○ Abnormal/loss of smell	○ Gynecologic	○ Excessive thirst
○ Frequent sore throat	○ Change in menstruation	○ Low blood sugar
○ Earaches	○ Heavy bleeding	○ Change in hair growth
○ Ear discharges	**Blood**	○ Excessive sweating
○ Nosebleeds	○ Anemia	○ Insufficient sweating
Cardiovascular	○ Easy bruising	**Neurological**
○ Chestpain or pressure	○ Easy bleeding	○ Dizziness/Imbalance
○ Palpitations/racing heart	○ Swollen lymph nodes	○ Numbness in arms/legs
○ Ankle swelling	○ Redness of skin	○ Tingling in arms/legs
○ Shortness of breath	**Skin**	○ Weakness in arms/legs
○ Difficulty breathing	○ Rashes	○ Tremors
○ History of Heart disease	○ Cancer	○ Loss of consciousness
○ History of Heart stents	○ Skin disease	○ Memory loss
○ History of leg stents	○ Itching	○ Confusion
○ Leg pain upon walking	○ Redness of skin	○ Seizures

Reviewed by: ____________________________ Date: ___________________