Nor Lea Neurology New Patient Form Page 1

Patient's Name: ____ Today's Date: ________________________________

Date of Birth: _________________________________

Past Medical History

Other Physician's name: _______________________________ What type of doctor?: _____________________________

Other Physician's name: _______________________________ What type of doctor?: _____________________________

Other Physician's name: _______________________________ What type of doctor?: _____________________________

Other Physician's name: _______________________________ What type of doctor?: _____________________________

Which of the following conditions are you currently being treated or have been treated for in the past (please check)

☐Heart disease	☐Seizure	☐Glaucoma	☐Diabetes
☐High cholesterol	☐Asthma	☐Seizures	☐Kidney Stones
☐High blood pressure	☐ Stroke	☐Stroke	☐Liver problems / Hepatitis
☐Low blood pressure	☐Sinus problems	☐Headaches / Migraines	☐Arthritis
☐Heartburn (reflux)	☐Seasonal allergies	☐ Cancer	☐Kidney Failure
☐Anemia	☐Tonsillitis	☐Depression / Anxiety	☐Ulcers
☐Swollen ankles	☐Ear problems	☐Thyroid problems	☐Fibromyalgia

Please describe any current or past medical treatment not listed above

____

____

Please list your past surgeries

____

____

____

Allergies

Are you allergic to penicillin or any other drugs? ☐Yes ☐No

Please list: ____

____

PLEASE COMPLETE REVERSE SIDE

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Social and Preventive History

Do you currently smoke or chew tobacco? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many packs per day? ______________________

Do you drink alcohol, beer, or wine? ☐Yes ☐No If no, have you in the past? ☐Yes ☐No
How many drinks per week? _____________________

Do you currently drink coffee and/or tea? ☐Yes ☐No If yes, how many cups per day? _______________________

Do you exercise daily/weekly? ☐Yes ☐No

Have you ever been sexually or physically abused? ☐Yes ☐No

Family History

	Living	Age (or age at death)	List serious illnesses
Mother	☐Yes ☐No	________________	____
Father	☐Yes ☐No	________________	____
Sisters	☐Yes ☐No	________________	____
	☐Yes ☐No	________________	____
	☐Yes ☐No	________________	____
Brothers	☐Yes ☐No	________________	____
	☐Yes ☐No	________________	____
	☐Yes ☐No	________________	____

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?
Anemia or Blood disease	____
Cancer	____
Diabetes	____
Migraine	____
Heart disease	____
High blood pressure	____
Bleeding in the Brain	____
Seizure___________	____
Stroke	____
Other serious illness	____

Females: Gynecological History

How many times have you been pregnant? _____________ Date of last Pap Smear: ___________________________

Date of last mammogram: ____________________________ Mammogram results: _____________________________

Have you ever had a breast biopsy? ☐Yes ☐No Biopsy results: ___________________________________

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature ____ **Date** ________________

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Please List your current medications