



# San Jose Pacific Neurology Center Professional Corporation

Fp2F4  
F4C4  
U4P4  
F4O2  
Fp1F3  
F3C3  
U3P3  
F3O1

## NEW PATIENT INFORMATION SHEET

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI

Referring Physician: \_\_\_\_\_

Do you want electronic prescription? ( Yes / No )

If yes, provide name and fax of pharmacy: \_\_\_\_\_

List names and phone/fax of physicians who should receive copies of your medical records:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe your main neurological problem. When was the onset?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list any chronic medical conditions (circle if applicable):

|                     |          |                         |            |
|---------------------|----------|-------------------------|------------|
| Hypertension        | Diabetes | Hypercholesterolemia    | Stroke/TIA |
| Atrial Fibrillation | Seizure  | Coronary artery disease | Depression |

Other: \_\_\_\_\_

List important surgeries done in the past with date if known:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List medication allergies with reactions:

\_\_\_\_\_

List all medications and dosage:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe if there are any significant medical problems in your family:

\_\_\_\_\_  
\_\_\_\_\_

Personal and social history:

Smoke ( Y / N )    Drink alcohol ( Y / N )    Illicit drugs (cocaine/marijuana, etc) ( Y / N )  
Married? ( Y / N )    Live alone or with family? \_\_\_\_\_  
Working ( Y / N )    If yes, what profession? \_\_\_\_\_



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## REVIEW OF SYSTEMS

Please indicate those that apply

### Dermatology:

- Rash.
- Lumps.
- Hives.

### Endocrinology:

- Fatigue.
- Excessive sweating.
- Excessive thirst.
- Heat intolerance.
- Cold intolerance.
- Diabetes.

### Neurology:

- Tingling numbness.
- Seizure/Convulsion.
- Dizziness.
- Memory problems.
- Tremors.
- Stroke.
- Difficulty Swallowing.
- Difficulty Speaking.
- Muscle Spasm.
- Incontinence.
- Headache.
- Weakness.
- Hearing Impairment.

### Ophthalmology:

- Diminished vision.
- Blurring of vision.
- Cataracts.
- Watery eyes.

### Hematology:

- Blood transfusion.
- Easy bruising.

### General:

- Weight change.
- Loss of appetite.
- Fever.
- Fatigue.
- Night sweats.
- Trouble Sleeping.

### ENT/respiratory:

- Cold.
- Hearing loss.
- Change in voice.
- Sore throat.
- Ringing in ears.
- Drooling.
- Shortness of breath.
- Sinus problems.
- Swollen Glands
- Thyroid Problems.
- Cough.

### Cardiology:

- Chest pain.
- Palpitations.
- Leg swelling.
- Shortness of breath.
- Murmurs.
- Valve Problems
- Mitral Prolapse/pfo.

### Gastroenterology:

- Nausea.
- Heartburn.
- Vomiting.
- Abdominal pain.
- Diarrhea.
- Constipation.
- Blood in stool.

### Musculoskeletal:

- Joint swelling.
- Joint pain.
- Leg cramps.
- Joint stiffness.
- Shooting leg pain.
- Shooting arm pain.
- Carpal Tunnel.
- Low back pain
- Scoliosis.
- Neck pain.
- Sciatic Nerve Problems.
- Herniated disc.

### Psychology:

- Tension/stress normal.
- Depression.
- Hyperactivity.
- Attention deficit.
- Irritability.
- Anxiety.
- Hallucinations.

### Genitourinary female:

- Lactation.
- Difficulty urinating.
- Infection.
- Warts/herpes.
- Urinary frequency.
- Dysmenorrhoea.
- Vaginal discharge.
- Hot flashes.

### Genitourinary male:

- Difficulty urinating.
- Urinary incontinence.
- Difficulty with erection.
- Impotence.
- Kidney Stones.
- Infection.
- Warts/herpes.
- Increased frequency of urination.