NEUROLOGICAL MEDICINE, P.A.
PATIENT DATA BASE

Name: _____ Date: _____
Age: _____ Date of Birth: _____ Handedness: Right _____ Left _____
Referring Physician: _____ Height: _____ Weight: _____
Family Doctor: _____
Please state in a few sentences the problem for which your physician referred you to our neurology office:

_____

_____.

List any tests done for this problem, where they were done, what they showed:

_____

_____

Have you lost time from work due to this problem? _____ When: _____

PAST MEDICAL HISTORY

Circle or check if you have had any of the following and indicate when:

	When		When
Diabetes		Cancer	
High blood pressure		Emphysema	
Heart attack		Asthma	
Stroke		Psychiatric disturbance	
Epilepsy		Depression	
Heart failure		Arthritis	
Ulcer		Lupus	
Glaucoma		Prostate problems	

SURGERY: (List all surgical operations)

Operation	Date	Physician	Hospital

HOSPITALIZATIONS: (List any problem requiring hospitalization – start with the most recent)

Problem	Date	Physician	Hospital

PHYSICIANS: (List other physicians have you consulted in the past 5 years?)

Problem	Date	Physician

INJURIES: (List any serious injuries, particularly to your head, neck or back)

_____

_____

_____

MEDICATIONS: (List all current medications)

Medication	Dosage	Date started

List any previous medications:

Medication	Reaction

ALLERGIES: (List medications and describe reaction)

Medication	Reaction

Other allergies? _____ Do you have asthma: _____

FOR FEMALE PATIENTS ONLY:

Birth control method : _____ Period regular? Yes _____ No _____
Last menstrual period: _____ Date of last pelvic exam: _____
Number of pregnancies: _____ Number of miscarriages: _____ Name of Gynecologist: _____

FOR MALE PATIENTS ONLY:

Impotence? _____ Loss of sexual abilities? _____

SOCIAL HISTORY

Marital Status: Married _____ Single _____ Divorced _____ Widowed _____ Separated _____
Employment/Occupation: _____ For how long? _____
If not working, when did you stop? _____ Previous Occupation: _____
How much do you smoke now? _____ Previously: _____
How often do you drink alcoholic beverages? _____
How much do you usually drink? _____
Education completed : _____

Have you had extensive exposure to chemicals or toxins?
Radiation _____ Asbestos _____ Coarse dusts_____ Loud noises_____

FAMILY HISTORY

Relative	Age/Ages if living	Present Health	Major illnesses State if past or present	If deceased, give age at death and cause
Father:				
Mother:				
Brothers:				
# living				
# deceased				
Sisters:				
# living				
# deceased				
Spouse:				
Children:				
# living				
# deceased				

CIRCLE ANY FOLLOWING PROBLEMS WHICH OCCURRED IN A MEMBER OF YOUR FAMILY

Diabetes
Headaches
Epilepsy, seizures or convulsions

Mental retardation
Nervous breakdown
Serious alcohol problem

High blood pressure
Stroke
Uncontrolled shaking or movements

Early memory loss
Psychiatric hospitalization
Arthritis

Heart attack
Poor coordination
Progressive weakness
Progressive numbness
Cancer
Severe depression

REVIEW OF SYSTEMS

Have you had (circle any that apply):

General

Decreased appetite
Increased appetite
Recent weight gain (# lbs.) _____
Recent weight loss (# lbs.) _____
Fever
Night sweats

Eyes

Double vision
Change in vision

Heart and Circulation

Chest pains
Palpitations
Rheumatic fever
Require two pillows to sleep
Late afternoon ankle swelling
Heart attack
Pacemaker

Urinary

Urinary frequency
Bladder infections
Regular awakening to pass urine
Burning when urinating
Loss of control of urine
Long pause before urine starts
Feeling of not being able to completely empty bladder

Ears, Nose, Mouth, Throat

Sore throat
Runny nose
Nasal polyps
Swollen glands
Ringing in ears
Pain in ears
Sensation of spinning or unsteadiness
Change in smell
Change in taste

Breathing

Shortness of breath
Cough
Coughing up blood
Pneumonia
Tuberculosis

Skin and Breasts

Herpes zoster (shingles)
Rash
Increased dryness of skin
Change in mole
Change in nails
Breast lump or swelling
Discharge from nipples

Allergic

Environmental allergens
Asthma
Drug reactions
Food reactions

Bones and Joints

Joint pain
Back pain
Sore muscles
Muscle spasm

Stomach and Bowels

Abdominal Pain
Nausea
Vomiting
Bloody stools
Change in bowel habits
Jaundice
Hernia
Hemorrhoids
Loss of control of bowels

Endocrine

Racing heart
Irregular periods

Frequent urination
Milk from breasts

Blood and Lymph

Bruising
Swollen glands
Anemia

Have you had (circle any that apply)

Brain and Nerves

Seizures, convulsions, epilepsy
Headache with nausea and vomiting
Muscle cramps
Unsteadiness in walking
Tremors

Fainting spells
Been knocked unconscious
Headache in one spot
Loss of muscle size
Leg cramps when walking
Change in speech
Stroke
Difficulty swallowing

Feeling of impending faint
Headache
Weakness all over
Weakness in one part of body
Difficulty with coordination
Change in handwriting
Recent persistent hoarseness

Pain, where? _____
Pins, needles or tingling feeling, where? _____
Numbness (loss of feeling), where? _____

Psychiatric

Trouble sleeping
Feel depressed
Take a drink to relax

Tire easily
Feel that others don't understand you
Psychiatric problems

Worry a lot
Feel nervous or tense
Psychiatric hospitalization

Physician Signature: _____ Date: _____

LAWRENCE R. WHICKER, JR., M.D.
MACIEJ POLTORAK, M.D., Ph.D.
SYED W. ASAD, M.D.
NABEEN HUSSAIN, M.D.
KENNETH M. KUDELKO, M.D.

NEUROLOGICAL MEDICINE, P.A.

7500 HANOVER PARKWAY • SUITE 201 • GREENBELT, MD 20770
(301) 982-7944 • FAX (301) 441-8696

THERE'S A FAST NEW WAY TO CONNECT WITH US!

Neurological Medicine, P.A. is pleased to provide our patients the *Allscripts Patient Portal*. Powered by Intuit Health, this is a self-service online tool that lets you connect with our practice where and when it fits your busy schedule.

Log onto WWW.NEUROMEDPA.COM *(secure and confidential)*. Click "*Patient Portal*."

***** PLEASE NOTE *****

When creating your account, please use a DESKTOP or LAPTOP computer as this is a secured network. Once you have successfully created an account, you will be able to log onto the patient portal from any device.

PORTAL FEATURES:

- ***APPOINTMENT REQUESTS***
  - Submit requests whenever you want, wherever you are, even when the office is closed.
- ***PRESCRIPTION RENEWALS***
  - Submit requests at home, on the road, or whenever you need.
- ***PRE-REGISTRATION FORMS***
  - Fill out forms at home and spend less time in the waiting room.
- ***SECURE MESSAGING***
  - Receive lab results, appointment reminders, office updates, and more.
- ***SYMPTOM MANAGEMENT***
  - Get a head start. Submit symptoms prior to visit, reducing time in the office.
- ***ASK A CLINICIAN***
  - Submit non-urgent questions to medical staff anytime.
- ***PERSONAL HEALTH RECORDS***
  - The simple way to access and manage your medical records.

PATIENT NAME: _____

EMAIL ADDRESS: _____

D.O.B. _____

ACCT # *(for office use only)*: _____

LAUREL MEDICAL ARTS PAVILION
7350 VAN DUSEN RD., SUITE 430
LAUREL, MD 20707

7500 HANOVER PKWY
SUITE 101A
GREENBELT, MD 20770

Please provide the office with your pharmacy information:

Patients Name: _____

Account # (office use only): _____

Retail Pharmacy Name: _____

Address: _____

Phone Number: _____

Mail Order Pharmacy: _____