

PMSI Division of Neurology
1569 Medical Drive, Suite 201
Pottstown, PA 19464

New Patient Encounter Form

Name _____

Handedness (circle one): Right handed / Left Handed / Ambidextrous

What symptoms or diagnosis prompted this referral to see a neurologist?

Medications you currently take? (Or provide a list to the receptionist)

Birth Control Pills: No Yes Over-the-counter (non-prescription) medications:
Aspirin: No Yes _____
Vitamins No Yes _____

Allergies to medicines/injections: No Yes If yes, please list: _____

Have you ever been treated for: (circle yes or no)

Diabetes Mellitus	No	Yes	Depression	No	Yes
High Blood Pressure	No	Yes	Anxiety	No	Yes
Elevated cholesterol	No	Yes	Peptic Ulcers	No	Yes
Heart Attack (MI)	No	Yes	Asthma	No	Yes

List other past or current medical diagnoses:

List hospitalizations/surgeries: _____

Systemic Review: Do you have problems with the following? If yes, please explain.

Feeling tired (fatigue): No Yes _____

Fever: No Yes _____

Recent weight loss: No Yes _____

Vision Problems: No Yes _____

Loss of hearing: No Yes _____

Nasal passage blockage: No Yes _____

Hoarseness: No Yes _____

Sore Throat: No Yes _____

Chest pain or Discomfort: No Yes _____

Difficulty Breathing: No Yes _____

Cough: No Yes _____

Abdominal Pain: No Yes _____

Pain during urination: No Yes _____

Feelings of Weakness: No Yes _____

Muscle aches: No Yes _____

Joint pain: No Yes _____

Numbness: No Yes _____

Have you ever had psychiatric are? No Yes

Have you ever been advised to seek psychiatric care? No Yes

For female patients: Number of children ____ Number of pregnancies ____ Number of miscarriages ____

SOCIAL HISTORY:

Circle one: Single Married Partnered Separated Divorced Widowed Do you live alone? Yes or No

Current job/career: _____

How much alcohol do you consume? _____

Current tobacco use? _____ packs per day.

Were you ever a heavy drinker? No Yes

Do you use street drugs? No Yes

Were you ever a smoker? No Yes

Family History:

Have you used street drugs? No Yes

Have any blood relatives had:

IF yes, which relation?

Heart Attack No Yes _____

High blood pressure No Yes _____

Breast Cancer No Yes _____

Lung Cancer No Yes _____

Colon Cancer No Yes _____

Migraine No Yes _____

Alzheimer's No Yes _____

Multiple Sclerosis No Yes _____

Diabetes No Yes _____

Stroke No Yes _____

Seizures No Yes _____

RELATIVE	If alive: Age?	If Deceased: Age at death and cause of death?	Medical Illnesses
Father			
Mother			
Brothers/Sisters			
Children			