

# Alpha Neurology PC

## Patient Updated Personal Information Sheet

\*\*\*\*\*Please complete all areas and present your current insurance card (s), along with this completed form, to the receptionist when arriving at the office for your appointment.

Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_ SS \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Phone # \_\_\_\_\_ Work# \_\_\_\_\_ Cell # \_\_\_\_\_

Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

Secondary Insurance \_\_\_\_\_ ID# \_\_\_\_\_

Subscriber Name \_\_\_\_\_ DOB \_\_\_\_/\_\_\_\_/\_\_\_\_

In an emergency, please contact \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Tel # \_\_\_\_\_

Primary Physician \_\_\_\_\_ Tel # \_\_\_\_\_

\*Please be sure to advise your physician at Alpha Neurology of any new allergies, surgeries or illnesses since your last visit to our office.

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Patient Signature

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Date

# Alpha Neurology PC

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**Reason for Today's Visit** \_\_\_\_\_

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| <p><b>Statistics:</b><br/> <input type="text"/> Height _____<br/> <input type="text"/> Weight _____</p> <p><b>Current Medications:</b><br/> <input type="text"/><br/> <input type="text"/><br/> <input type="text"/><br/> <input type="text"/><br/> <input type="text"/><br/> <input type="text"/><br/> <input type="text"/></p> <p><b>NEUROLOGICAL</b></p> <p><input type="checkbox"/> Dizziness<br/> <input type="checkbox"/> Vertigo<br/> <input type="checkbox"/> Memory loss<br/> <input type="checkbox"/> Disorientation<br/> <input type="checkbox"/> Speech or language dysfunction<br/> <input type="checkbox"/> Inability to concentrate<br/> <input type="checkbox"/> Seizures<br/> <input type="checkbox"/> Taste, smell or touch disturbance<br/> <input type="checkbox"/> Headache<br/> <input type="checkbox"/> Migraine headache<br/> <input type="checkbox"/> Numbness or Tingling<br/> <input type="checkbox"/> General weakness<br/> <input type="checkbox"/> Muscle weakness<br/> <input type="checkbox"/> Slurred Speech<br/> <input type="checkbox"/> Blurred vision<br/> <input type="checkbox"/> Loss of consciousness<br/> <input type="checkbox"/> Balance problems<br/> <input type="checkbox"/> Falls<br/> <input type="checkbox"/> Depression<br/> <input type="checkbox"/> Fatigue<br/> <input type="checkbox"/> Neck pain<br/> <input type="checkbox"/> Back pain</p> <p><b>CONSTITUTIONAL</b></p> <p><input type="checkbox"/> Fatigue (sluggish, tired)<br/> <input type="checkbox"/> Weight loss<br/> <input type="checkbox"/> Weight gain<br/> <input type="checkbox"/> Weight stable<br/> <input type="checkbox"/> Night Sweats<br/> <input type="checkbox"/> All negative</p> | <p><b>MUSCULOSKELETAL</b></p> <p><input type="checkbox"/> Muscle cramping<br/> <input type="checkbox"/> twitching or pain<br/> <input type="checkbox"/> Joint swelling<br/> <input type="checkbox"/> Joint stiffness<br/> <input type="checkbox"/> Joint pain<br/> <input type="checkbox"/> Noise with joint movement<br/> <input type="checkbox"/> Arm or leg pain<br/> <input type="checkbox"/> All negative</p> <p><b>SKIN</b></p> <p><input type="checkbox"/> Itching<br/> <input type="checkbox"/> Scars<br/> <input type="checkbox"/> Moles or lesions<br/> <input type="checkbox"/> Changes in color of moles or lesions<br/> <input type="checkbox"/> Rashes<br/> <input type="checkbox"/> All negative</p> <p><b>PSYCHIATRIC</b></p> <p><input type="checkbox"/> Anxiety<br/> <input type="checkbox"/> sleep disturbance<br/> <input type="checkbox"/> Hallucinations<br/> <input type="checkbox"/> All negative</p> <p><b>CARDIOVASCULAR</b></p> <p><input type="checkbox"/> Chest pain<br/> <input type="checkbox"/> Palpations<br/> <input type="checkbox"/> Heart Murmur<br/> <input type="checkbox"/> Irregular pulse<br/> <input type="checkbox"/> High blood pressure<br/> <input type="checkbox"/> Low blood pressure<br/> <input type="checkbox"/> Swelling<br/> <input type="checkbox"/> Coldness/numbness in fingers or toes<br/> <input type="checkbox"/> All negative</p> <p><b>EYES</b></p> <p><input type="checkbox"/> Itching<br/> <input type="checkbox"/> Excessive tearing<br/> <input type="checkbox"/> Double vision<br/> <input type="checkbox"/> Light sensitivity<br/> <input type="checkbox"/> All negative</p> <p><b>RESPIRATORY</b></p> <p><input type="checkbox"/> Difficulty breathing<br/> <input type="checkbox"/> Chronic cough<br/> <input type="checkbox"/> Asthma<br/> <input type="checkbox"/> Bronchitis<br/> <input type="checkbox"/> All negative</p> | <p><b>GENITOURINARY</b></p> <p><input type="checkbox"/> Painful urination<br/> <input type="checkbox"/> Frequent Urination<br/> <input type="checkbox"/> Night urination<br/> <input type="checkbox"/> Unable to control urination<br/> <input type="checkbox"/> All negative</p> <p><b>ENDOCRINE</b></p> <p><input type="checkbox"/> Diabetes<br/> <input type="checkbox"/> Adrenal problems<br/> <input type="checkbox"/> Changes in height or weight<br/> <input type="checkbox"/> Increased appetite<br/> <input type="checkbox"/> Increased thirst<br/> <input type="checkbox"/> Hair change/loss<br/> <input type="checkbox"/> All negative</p> <p><b>HEMATOLOGIC/LYMPHATIC</b></p> <p><input type="checkbox"/> Anemia<br/> <input type="checkbox"/> Bleeding tendencies<br/> <input type="checkbox"/> Easy bruising<br/> <input type="checkbox"/> Fatigue<br/> <input type="checkbox"/> Recurrent infections<br/> <input type="checkbox"/> Slow healing from cuts<br/> <input type="checkbox"/> All negative</p> <p><b>ALLERGIC/IMMUNOLOGIC</b></p> <p><input type="checkbox"/> Hay fever<br/> <input type="checkbox"/> Itching<br/> <input type="checkbox"/> Sneezing<br/> <input type="checkbox"/> Chronic clear nasal drainage<br/> <input type="checkbox"/> Conjunctivitis<br/> <input type="checkbox"/> Allergies to Medication<br/> <input type="checkbox"/> All negative</p> <p><b>ENMT</b></p> <p><input type="checkbox"/> Sensitivity to noise<br/> <input type="checkbox"/> Ear Pain<br/> <input type="checkbox"/> Ringing in the ear<br/> <input type="checkbox"/> Nosebleeds<br/> <input type="checkbox"/> Sinusitis<br/> <input type="checkbox"/> Vertigo<br/> <input type="checkbox"/> Post nasal drip<br/> <input type="checkbox"/> Bleeding gums<br/> <input type="checkbox"/> Hoarseness<br/> <input type="checkbox"/> Difficulty Swallowing<br/> <input type="checkbox"/> All negative</p> |
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Patient Signature \_\_\_\_\_

HealthCare Provider Signature \_\_\_\_\_

# Alpha Neurology PC

Name \_\_\_\_\_ Date \_\_\_\_\_

**PAST Medical History:** Have you been diagnosed with any of the following?

Heart Disease       Parkinson's disease       Neuropathy       Lupus       Obesity  
 Coronary Artery Disease       Multiple Sclerosis       Stroke       Gout       COPD/Emphysema  
 Diabetes Mellitus       Pacemaker       Rheumatoid Arthritis       Carpal Tunnel       High Cholesterol

Other \_\_\_\_\_

Previous Surgeries \_\_\_\_\_

**Family History:**

|                           | Father                   | Mother                   | Maternal<br>Grandmother  | Maternal<br>Grandfather  | Paternal<br>Grandmother  | Paternal<br>Grandfather  |
|---------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Stroke                    | <input type="checkbox"/> |
| Seizure                   | <input type="checkbox"/> |
| Multiple Sclerosis        | <input type="checkbox"/> |
| Parkinson's Disease       | <input type="checkbox"/> |
| Migraine Headache         | <input type="checkbox"/> |
| Neuropathy                | <input type="checkbox"/> |
| Heart Disease             | <input type="checkbox"/> |
| Respiratory Disease       | <input type="checkbox"/> |
| Cancer                    | <input type="checkbox"/> |
| Psychiatric Disorder      | <input type="checkbox"/> |
| Sudden, unexplained death | <input type="checkbox"/> |

**Social History:**

Smoking:       Yes, how many packs per day? \_\_\_\_\_       No, never       Quit, when \_\_\_\_\_

Alcohol Use:       Daily       Socially

Recreational Drug use:       Yes       No

Employment:       Employed       Part Time       Unemployed       Retired

Marital Status:       Single       Married/Cohabitating       Divorced/Separated       Widowed

Have you, or a close family member or friend recently suffered any emotional stress: such as losing a job, a divorce, moving to a new location? If yes, please explain \_\_\_\_\_

**If a Physician referred you to our office, please  
list his/her name or list a Physician's name you  
would like us to send a report to.**

**Dr's Name \_\_\_\_\_**

**Address \_\_\_\_\_**

Patient Signature

Reviewing Physician's Signature