Avtar Singh, MD
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T (914) 723 8100

NEUROLOGY NEW PATIENT FORM

Patient Name: _____ DOB: _____ Date: _____

Name of Physician you are seeing today: _____

Dominant Hand: □ Right □ Left □ Ambidextrous

Referring Provider: _____

Address: _____

Primary Care Provider: _____

Address: _____

Pharmacy Name (Include Address **and/or** Phone): _____

The reason for your visit: _____

When did these symptoms start? _____

Do you have a history of any of the following conditions/problems? (*Please check all that apply*)

	YES		**YES**		**YES**
Memory Loss		Unexplained Fever		Cirrhosis	
Loss of Consciousness		Weight Loss/Gain		Blood in the urine/stool	
Dizziness/Vertigo		Changes in Appetite/Thirst		Stool/Urine Incontinence	
Seizures/Epilepsy		Fatigue/Poor Energy		Urinary Frequency/Retention	
Tremors		Heart Attack		Constipation/Diarrhea	
Glasses/Contacts		Angina/Chest Pain		Rash/Changing Moles	
Visual Loss		Heart Failure		Diabetes Mellitus	
Double/Blurred Vision		Abnormal Heart Rhythm		Thyroid Problems	
Loss of Hearing		Fainting/Passing out		Sexual Dysfunction	
Ringing in the ears		High Blood Pressure		Trouble Thinking	
Sinus/Ear Discharge		Blood Clots/Phlebitis (DVT)		Hallucinations	
Difficulty Swallowing		High Cholesterol		Tuberculosis	
Hoarse Voice		Shortness of Breath/Wheezing		HIV/AIDS	
Loss of smell		Unexplained Cough		Easy Bleeding/Bruising	
Headache		Asthma/COPD/Emphysema		Enlarged Lymph Nodes	
Sleeping Troubles		Hyperventilation		Limb Swelling	
Back/Neck/Face Pain		Pulmonary Embolus		Miscarriages	
Leg Pain/Sciatica		Abdominal Pain		Irregular Menses	
Muscle Pain		Unexplained Nausea/Vomiting		Cancer	
Joint Pain/Swelling		Stomach/Intestinal Bleeding		Hepatitis	
Arthritis		Ulcers		Other (List Below)	
Weakness		Heartburn/Reflux			
Clumsiness/Poor Balance		Jaundice			
Tremor/Shaking		Heat/Cold Intolerance			
Falling/Difficulty Walking		Panic Attacks			
Numbness/Tingling		Depression/Anxiety			
Parkinson's Disease		Mood Changes			

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NEUROLOGY NEW PATIENT FORM

Patient Name: _____ DOB: _____ Date: _____

FAMILY HISTORY: (*Please add names of family members*)

Family Member	**Alive**	**Deceased (Age)**	**Illness**
Mother:			
Father:			
Sibling:			
Sibling:			
Sibling:			
Child:			
Child:			
Child:			

List any neurological diseases in your family: _____
List all Hospitalizations and Operations (*Include year*): _____
_____
_____

ALLERGIES: ☐ No Allergies

Allergies	Type of Reaction		Medication Allergies	Type of Reaction

LIST ALL MEDICATIONS YOU ARE TAKING (*Prescription, Over-the-counter, or Herbal*) ☐ None

Medication	Dosage	How Often Taken		Medication	Dosage	How Often Taken

SOCIAL HISTORY:

Tobacco Use? ☐ Yes ☐ No ☐ Former Do you consume alcohol? ☐ Yes ☐ No ☐ Former

Type of Tobacco	Packs/Day	For (# Of Yrs.)	Yr. Quit		Type of Alcohol	Frequency	Amount	Last Drink
Cigarettes								
Other:								

Exposed to second hand smoke? ☐ Yes ☐ No

Caffeine Consumption? ☐ Yes ☐ No Type: _____ Amount per day? _____

Do you exercise? ☐ Yes ☐ No Type: _____ How often? _____

****FOR WOMEN**:

Are you pregnant? ☐ Yes ☐ No If no, last menstrual period? _____
If menopausal, at what age? _____