### Sample Neurological H&P

#### CC:

The patient is a 50-year-old right-handed woman with a history of chronic headaches who complains of acute onset of double vision and right eyelid droopiness three days ago.

#### History of present illness:

Mrs. Smith states that on Sunday evening (7/14/03) about 20 minutes after sitting down to work at her computer, she developed blurred vision, which she describes as the words on the computer looking fuzzy and seeming to run into each other. When she looked up at the clock on the wall, she had a hard time making out the numbers. At the same time, she also noted a strange sensation in her right eyelid. She went to bed and upon awakening the following morning, she was unable to open her right eye. When she lifted the right eyelid with her fingers, she had double vision with the objects appearing side by side. The double vision was most prominent when she looked to the left, but was also present when she looked straight ahead, up, down, and to the right, and went away when she closed either of her eyes. She also noted that she had pain in both of her eyes that increased if she moved her eyes around, especially on looking to the left. She was seen in the Alton Memorial Hospital ER and subsequently transferred to BJH by ambulance.

Mrs. Smith also notes that for the past two to three weeks, she has been having intermittent pounding bifrontal headaches that worsen with straining, such as when coughing or having a bowel movement. The headaches are not positional and are not worse at any particular time of day. She rates the pain as 7 or 8 on a scale of 1 to 10, with 10 being the worst possible headache. The pain lessened somewhat when she took Vicodin that she had lying around. She denies associated nausea, vomiting, photophobia, loss of vision, seeing flashing lights or zigzag lines, numbness, weakness, language difficulties, and gait abnormalities. Her recent headaches differ from her “typical migraines,” which have occurred about 4-6 times per year since she was a teenager and consist of seeing shimmering white stars move horizontally across her vision for a couple minutes followed by a pounding headache behind one or the other eye, photophobia, phonophobia, and nausea and vomiting lasting several hours to two days. She has never taken anything for these headaches other than ibuprofen or Vicodin, both of which are partially effective. The last headache of that type was two months ago.

Her visual symptoms have not changed since the initial presentation. She denies previous episodes of transient or permanent visual or neurologic changes. She denies head trauma, recent illness, fever, tinnitus or other neurologic symptoms. She is not aware of a change in her appearance, but her husband notes that her right eye seems to protrude; he thinks that this is a change in the last few days.

#### Past medical history:

1. Migraine headaches, as described in HPI.
2. Depression. There is no history of diabetes or hypertension.

#### Medications:

Zoloft 50 mg daily, ibuprofen 600 mg a few times per week, and Vicodin a few times per week.

#### Allergies:

None.

#### Social history:

The patient lives with her husband and 16-year-old daughter in a 2-story single-family house and has worked as a medical receptionist for 25 years. She denies tobacco or illicit drug use and rarely drinks a glass of wine.

#### Family history:

Her mother had migraines and died at the age of 70 after a heart attack. Her maternal grandfather had a stroke at age 69. There is no other family history of stroke or vascular disease, but she has no information about her father’s side of the family.

#### Review of systems:

She states that she had an upper respiratory infection with rhinorrhea, congestion, sore throat, and cough about 6 weeks ago. She denies fever, chills, malaise, weight loss, neck stiffness, chest pain, dyspnea, abdominal pain, diarrhea, constipation, urinary symptoms, joint pain, or back pain. Neurologic complaints as per HPI.

#### General physical examination:

The patient is obese but well-appearing. Temperature is 37.6, blood pressure is 128/78, and pulse is 85. There is no tenderness over the scalp or neck and no bruits over the eyes or at the neck. There is no proptosis, lid swelling, conjunctival injection, or chemosis. Cardiac exam shows a regular rate and no murmur.

#### Neurologic examination:

**Mental status:**  
The patient is alert, attentive, and oriented. Speech is clear and fluent with good repetition, comprehension, and naming. She recalls 3/3 objects at 5 minutes.

**ranial nerves:**  
CN II: Visual fields are full to confrontation. Fundoscopic exam is normal with sharp discs and no vascular changes. Venous pulsations are present bilaterally. Pupils are 4 mm and briskly reactive to light. Visual acuity is 20/20 bilaterally.

CN III, IV, VI: At primary gaze, there is no eye deviation. When the patient is looking to the left, the right eye does not adduct. When the patient is looking up, the right eye does not move up as well as the left. She develops horizontal diplopia in all directions of gaze especially when looking to the left. There is ptosis of the right eye. Convergence is impaired.

CN V: Facial sensation is intact to pinprick in all 3 divisions bilaterally. Corneal responses are intact.

CN VII: Face is symmetric with normal eye closure and smile.

CN VII: Hearing is normal to rubbing fingers

CN IX, X: Palate elevates symmetrically. Phonation is normal.

CN XI: Head turning and shoulder shrug are intact

CN XII: Tongue is midline with normal movements and no atrophy.

**Motor:**  
There is no pronator drift of out-stretched arms. Muscle bulk and tone are normal. Strength is full bilaterally.

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