New Patient Consult Form

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Fill out relevant information, highlight where appropriate, email your completed form to ***info@myneuro.care***

First and Last Name:	Date of birth:	Age:
Cell phone #:	emergency contact (name and cell #):	
Work phone #:	Patient's email:	
Home address:		
Insurance carrier		
Name and fax of the doctor/s who you would like to receive consultation report		
Please indicate yes or no if you would like to receive a copy of your final consultation report Yes No		

Please fill in the details in the space below about current symptoms with exacerbating and relieving factors

My neurological issue began on: **while I was**:
My symptoms are: *(be specific, example: numbness, burning pain in my left arm)*
What part of the body does the problem affect? _____ What types of symptoms _____ How long have you had the problem?_____ How often do the symptoms occur?_____ How long do the symptoms last?
My symptoms are worse if I: (ex: walk, lay on my back)
My symptoms are better if I:
Medications I've tried for this issue are (*include the dosage and frequency*):
Most helpful medications were:
The consult/testing I had for this issue was done by Dr. (*insert name of the specialist) at (insert location*)

I had these tests for my issue (*please indicate the* ***exact year*** *of the studies and* ***location of the testing center***)

scans of my brain with CT/MRI on (*insert the exact year in here):*	This test was done at:
scans of my spine with CT/MRI on (*insert the exact year:*	test was done at: _____
scans of blood vessels in the neck (*insert the exact year:*	test was done at:
ultrasound of my neck vessels (Carotid US) *year:*	test was done at:
ultrasound of my heart (Echocardiogram) year:	test was done at:_____
heart monitoring for arrhythmia (Holter monitor) *year*:	test done at:
brain wave test, electroencephalogram (EEG) on this date and year	test done at:

muscles and nerve conduction test (EMG/NCS) on this date and year test done at:_____
Please list any other tests that you had and think may be relevant:

Please indicate below what you would like to get out of this consultation so I can best meet your needs

M**y hopes and expectations out of this consult are:** (ex: to understand the nature of my current symptoms)

PAST MEDICAL HISTORY

My medical history	*highlight conditions that you have*	*read carefully through all of these*
High blood pressure	Diabetes – not on Insulin	Narcolepsy
Heart disease with no heart attacks	Diabetes – on Insulin	Restless leg syndrome
Heart attacks and interventions	Hyperthyroidism	REM behavior sleep disorder
sleep apnea – on CPAP	Low thyroid state (hypothyroid)	Anxiety
sleep apnea – not on CPAP	Trouble sleeping	Depression – well controlled
High cholesterol	Acid Reflux	Depression – not well controlled
History of stroke	Vitamin D deficiency	Liver disease – Hepatitis C, B, fatty liver or cirrhosis
Head injury	Macular degeneration	Heart disease with no heart attacks
Migraines	Glaucoma	Irregular heart rate (Afib)
Parkinson's Disease	Arthritis of hands	History of addiction to gambling
Aortic Stenosis		Syphilis
Stomach Ulcers	History of chemotherapy	Immune Disorder
Anemia	History of radiation treatment	Heart Failure
Peripheral painful neuropathy	Arthritis of back	Skin cancer
Leukemia	Cancer	Deep Vein Thrombosis
Lymphoma	Kidney Failure disease	Blood Clotting Disorder
Brain Tumor	Blood Vessel Blockage	Urinary Incontinence
Alcohol Problem	Artificial Valve - Mechanical	Tuberculosis
Seizure Disorder	Artificial Valve – Pig valve	Arthritis of neck
Asthma	Dementia	Rheumatoid arthritis
Emphysema/COPD	Bipolar disorder	Systemic Lupus
Pulmonary fibrosis	Schizophrenia/ schizoaffective	Fibromyalgia
Insert additional medical problems into the blank spaces	*Insert additional medical problems into the blank spaces below*	*Insert additional medical problems into the blank spaces below*

ALLERGIES

My allergies are: none

I am allergic to *highlight relevant to you*	Sulfa *Reaction:*	Latex *Reaction:*	IV contrast *Reaction:*	shell fish *Reaction:*	Penicillin *Reaction:*

List any others:

MEDICATIONS *(please include injectable medications and infusions such as chemotherapy, iron or IVIG)*

My current medications and **supplements**	Medication dose	How often taken

PAST SURGICAL HISTORY

My past surgeries are	*highlight the surgeries that are relevant to you*
Pacemaker	Heart stents/ angioplasty
Carotid artery surgery	Appendix removal
Gallbladder removal	Stomach surgeries
Hysterectomy	Tonsil removal
Arthroscopic knee surgery	Total knee replacement
Hip replacement	Cataracts
Hernia Repair	Neck surgery - discectomy at these levels
Neck cervical fusion and screws at these levels	Back surgeries - discectomy at these levels
Back surgery fusion and screws placement at	Heart Coronary Bypass Graft
any other surgeries please list in here:	

SOCIAL HISTORY (*highlight sections that are relevant to you and fill in the blanks on occupation/hobbies)*

I am single	I live by myself	My current occupation is:
I am married	I live with family	My prior occupation was: I retired at age:
I am divorced	I live with a partner	I am on a permanent/temporary disability for:
I am widowed	I live with my spouse	My favorite hobbies include:

TOBACCO USE (*highlight the sections that are relevant to you and fill in the relevant years and numbers)*

I do not smoke and never have I do not smoke but did in the past	Previously smoked __ packs per day for this many years __	I quit on ____ I am trying to quit

RECREATIONAL DRUG USE (*highlight the sections that are relevant to you and fill in the blanks*)

I use marihuana for medicinal reasons which include: *list below*	I have been using marihuana recreationally for __ years	I quit using marihuana the year of ____ I quit using other recreational drugs the year of ____	I do not use illicit drugs currently and never have used them in the past	I do not use illicit drugs but have use them extensively in the past including: crack, cocaine, LSD, methamphetamines, mushrooms, *list any others below:*

ALCOHOL USE (*highlight the sections that are relevant to you and fill in the relevant years and numbers*)

I do not drink alcohol	I quit heavy drinking the year of	I drink rarely, <3 times per month
I consume alcohol socially on average __ drinks per week	In the past, I drank heavily ___ ounces of (beer, hard liquor, wine, other __) for __ number of years	I drink daily ___ ounces of (beer, liquor, wine, other ____ drinks per day for the past ___years

CAFFEINE INTAKE

Coffee	I drink ___ cups of coffee per day ___ days per week	I am interested in cutting back on coffee
Black tea	I drink __ cups of black tea per day ___days per week	I am interested in cutting back on black tea
Caffeinated soda	I drink ___ cans of soda per day ___ days per week	I am interested in cutting back on caffeinated soda

EXERCISE

I do not exercise *Please specify reasons below:*	I exercises very rarely	I am a regular exerciser and exercise on average ___times per week doing the following activities:

STRESS AMOUNT (*highlight the sections that are relevant to you, fill out the info on stress relief activities)*

I have excess stress in my life	I do not have excess stress in life	My Stress relief tools are:
I do not actively manage my stress	I would be interested in learning stress management techniques	reading, yoga, massage, music, exercise
I actively manage my stress	I am not interested in stress management techniques	*insert your activities here*

SLEEP AMOUNT

My sleep	On average I get about this many hours (insert the number here) of sleep per night

FAMILY HISTORY *specify any chronic medical and neurological conditions present in your family members*

Mother	Father
Sister/s	Brother/s
Daughter/s	Son/s
Mother's Mom	Father's Mom
Mother's Dad	Father's Dad

REVIEW OF SYSTEMS

If you have any symptoms in the following areas, check 'yes' or 'no' or highlight the appropriate areas below

System	Yes	No	Your Comments	Neurologist's comments
CONSTITUTIONAL				
Recent weight loss				
Recent weight gain				
Recurrent fevers, chills, sweats				
Extreme fatigue				
EYES				
Blurred vision				
Glaucoma				
Eye pain with movement				
Loss of vision				
Double vision				
Eye redness				
Eye dryness				
GASTROINTESTINAL				
Abdominal pain				
Black or bloody stools				
Constipation				
Vomiting blood				
Severe heartburn				
Change in appetite				
CARDIOVASCULAR				
Chest Pain or Angina				
Irregular heart rhythm				
Swelling of the feet				
ENT				
Change in hearing				
Ringing in the ears				
Recent nose bleeds				
Chronic sinus problems				
Voice changes				
Loss of balance				
Ear pain				
Ear discharge or ear rash				
Hoarseness				
Trouble swallowing				

GENITOURINARY				
Blood in urine				
Burning with urination				
Difficult/frequent urination				
Lack of bladder control				
Sexually transmitted disease				
Change in sexual function				
HEMATOLOGIC				
Easy bruising				
Frequent bleeding				
Enlarged lymph nodes				
MUSCULOSKELETAL				
Muscle pain				
Muscle cramp				
Muscle twitches				
Loss of muscle				
Neck pain				
Back pain				
Joint pain				
Joint stiffness				
Joint swelling				
PSYCHIATRIC				
Nervousness/Anxiety				
Suicidal thoughts				
Inappropriate crying				
Depression				
Trouble sleeping				
Visual hallucinations				
Auditory hallucinations				
Irritability, anger				
RESPIRATORY				
Chronic cough				
Breathing problems				
Coughing up blood				
INTEGUMENTARY				
Unusual rashes				
Breast pain or lump				
Change in hair or nails				
ALLERGIC / IMMUNOLOGIC				
Low resistance to infection				
Environmental allergies				
Skin rash				
Joint pain and stiffness				
NEUROLOGIC				

Numbness/tingling sensation				
Weakness or paralysis				
Convulsions or seizures				
Change in memory/concentration				
Loss or blurring of vision, or double vision				
Blackout/syncope				
Memory loss or confusion				
Other neurological problems				
Face pain				
Headaches				
Tremors				
Clumsiness				
Slurred speech				
Vertigo – spinning sensation				
ENDOCRINE				
Feeling cold most times				
Feeling hot most times				
Excessive thirst				
Excessive urination				
Hair loss				
Constipation				
Dry skin				
Dry eyes and mouth				
Leg swelling				

ANY ADDITIONAL INFORMATION THAT WAS NOT COVERED BY ABOVE SECTIONS

Please indicate below any other information pertaining to your medical health, your past social history, prior injuries, toxic exposures that you think would be useful for Dr.Nikolskaya to have prior to your consultation.

I give permission for the following people to discuss my care with Dr.Nikolskaya and her staff.

Name and
Relationship _____
_____

Patient's Signature:_____ Date:_____