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Fax: [(413) 749-5954](tel:(413)%20749-5954)Diplomate, American Board of Psychiatry & Neurology (ABPN)

Website: Myneuro.care

*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)* |
|  |
|  |
| **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:* |

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*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: | | | | | |

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

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

**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 |

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**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 |

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**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 |  |  |  |  |
| **EAR, NOSE, AND THROAT** |  |  |  |  |
| 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 me to have prior to your consultation*. |

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