



# DENT NEUROLOGIC INSTITUTE

## New Patient History Form

Today's Date \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

1. Please describe the problem that you would like addressed, e.g., what it consists of, how and when it started, what worsens and relieves it.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2a. Who is your <b>primary physician with address</b> (if known)?	2b. What physicians have you seen for this problem?
_____	_____
_____	_____

3. List all illnesses and/or hospitalizations/surgeries you have had during your life:

_____	_____
_____	_____
_____	_____
_____	_____

4. List the name and dose for each prescription and over-the-counter medication you are currently taking:

Drug: _____	Dose: _____
_____	_____
_____	_____
_____	_____
_____	_____

5. Any drug allergy?

<u>Drug</u>	<u>Reaction</u>
_____	_____
_____	_____
_____	_____

6. What has been done for your problem? Medications? Physical therapy? Surgery? Other?

<u>Treatment</u>	<u>Date</u>	<u>Results</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. Other problems? Please **circle** the ones that apply to you:

Neurologic

Headache, change in taste, smell or hearing, slurred speech, difficulty swallowing, dizziness, weakness, numbness, loss of consciousness, fainting, seizure, unsteadiness, falls, tremor, confusion, memory loss, head trauma, sleep problem, stroke/TIA (mini-stroke).

Constitutional

Fever, chills, fatigue, weight gain or loss, HIV/AIDS

Eyes

Blurry vision, double vision, decreased vision, cataract, glaucoma.

Ears, Nose, Mouth, Throat

Hearing loss, ringing in the ears, earache, hoarseness, vertigo (spinning).

Cardiovascular

Chest pain, palpitations, leg edema, high blood pressure, heart attack, coronary artery disease/surgery, shortness of breath when lying down or on exertion, heart failure.

Respiratory

Cough, emphysema, asthma.

Gastro-Intestinal

Nausea, vomiting, heartburn, ulcers, abdominal pain, diarrhea, constipation, hepatitis.

Genito-Urinary

Urinary incontinence/frequency/urge, sexual dysfunction, kidney problems.

Skin

Rash or other skin abnormality.

Musculoskeletal

Joint pain/swelling/stiffness, neck/lower back pain, muscle aches.

Psychiatric

Depression, anxiety, other psychiatric problems.

Continued from #7

Endocrine

Diabetes, thyroid problems, hormonal problems.

Hematologic

Anemia, easily bruises, bleeding disorder.

Allergy

Itching, rash, swollen lips/tongue.

Have you ever had cancer? \_\_\_ No \_\_\_ Yes, describe \_\_\_\_\_

8. Have you had any of the following tests?

<u>Test</u>	<u>Date</u>	<u>Where</u>
MRI	_____	_____
CT	_____	_____
Carotid Doppler	_____	_____
EMG	_____	_____
EEG	_____	_____
SPECT/PET	_____	_____
Other (myelogram, angiogram, biopsy, spinal tap):		
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Do you use tobacco? \_\_\_ No \_\_\_ Yes, pack per day \_\_\_\_, # of years \_\_\_ Quit date \_\_\_\_\_

Do you use alcohol? \_\_\_ No \_\_\_ Yes, amount \_\_\_\_\_

Who lives with you at home? \_\_\_\_\_

Describe your work: \_\_\_\_\_

Disability? \_\_\_\_\_ No \_\_\_\_\_ Yes, since \_\_\_\_\_

10. Tell us about your family's health:

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother #1: \_\_\_\_\_ Sister #1: \_\_\_\_\_

Brother #2: \_\_\_\_\_ Sister #2: \_\_\_\_\_

Brother #3: \_\_\_\_\_ Sister #3: \_\_\_\_\_

Brother #4: \_\_\_\_\_ Sister #4: \_\_\_\_\_

11. What do you hope to achieve with your doctor?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

12. Emergency contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Mobile Phone: \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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Visit our website at [www.dentoinstitute.com](http://www.dentoinstitute.com) and take our on-line survey.

For office use only:

BP \_\_\_\_\_ Pulse \_\_\_\_\_ Resp. \_\_\_\_\_ Wt. \_\_\_\_\_ Ht. \_\_\_\_\_

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