Dr. Arbi Ohanian
Neurology
Patient Evaluation and Management Services

Date:_____

Name: _____DOB:_____ Gender: (F M)

Referring Physician:
_____FamilyPhysician_____

Other treating physicians in the past five years: PLEASE LIST

Name **Phone**

1._____

2_____

3_____

4_____

What is the current problem for which you are here? (Chief Complaint)

When did it start? **If injury, date**

Are you getting worse?

<u>Review of Systems:</u> Have you ever had any of these symptoms?

<u>Please check the symptoms that best describe your condition.</u>

●Constitutional Symptoms
- ☐ Fever
- ☐ Night sweat
- ☐ Weight loss

●Cardiovascular
- ☐ Shortness of Breath
- ☐ Chest Pain
- ☐ Irregular heart beat

●Respiratory
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Emphysema
- ☐ Bronchitis
- ☐ Palpitations
- ☐ Asthma

●Gastro-intestinal
- ☐ Weight loss
- ☐ Blood in stool
- ☐ Dark colored stool
- ☐ Abdominal pain
- ☐ Hernia
- ☐ Difficulty swallowing
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal distention
- ☐ Diarrhea
- ☐ Constipation
- ☐ Abdominal mass or lumps

●Genito-Urinary
- ☐ Any burning of urination
- ☐ Dark or discolored urine
- ☐ Difficulty starting/ending urine stream
- ☐ Poor control of bladder
- ☐ Excessive thirst
- ☐ Any type of sexual dysfunction
- ☐ Inability to obtain/maintain erection
- ☐ Loss of sensation, genitals

●Endocrine
- ☐ Discharge from nipples
- ☐ Poor appetite
- ☐ Cold intolerance
- ☐ Dry skin
- ☐ Excessive thirst
- ☐ Loss of body hair
- ☐ Anxious
- ☐ Weight gain
- ☐ Weight loss

●Skin and breast
- ☐ Dry skin
- ☐ Discharge from nipples

●Psychiatric
- ☐ Depression
- ☐ Disorientation
- ☐ Hallucination
- ☐ Euphoria
- ☐ Anxiety

●Hematologic/lymphatic
- ☐ Easy bruising
- ☐ Nose bleeds

●Allergic/immunologic
- ☐ Body Rash

●Musculoskeletal
- ☐ Swelling
- ☐ Masses
- ☐ Neck pain
- ☐ Neck spasm
- ☐ Cramps
- ☐ Abnormal arm or leg feelings
- ☐ Arm or leg weakness
- ☐ Back pain
- ☐ Weakness
- ☐ Loss of control of arms or legs
- ☐ Poor coordination
- ☐ Numbness
- ☐ Tingling
- ☐ Loss of sensation
- ☐ Loss of muscle bulk

●Neurological
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Double vision
- ☐ Loss of hearing (one or both)
- ☐ Ringing in ears
- ☐ Numbness in face
- ☐ Decreased ability to smell
- ☐ Decreased ability to taste
- ☐ Droopy face or eye
- ☐ Hoarseness
- ☐ Difficulty speaking
- ☐ Difficulty swallowing
- ☐ Slurred speech
- ☐ Headache
- ☐ Dizziness
- ☐ Seizures

Name: **Date:**

Please explain any of the above problems that you have checked:

PAST MEDICAL HISTORY:

• Please list all prior major illness, injuries or surgeries: Date:

Have you ever had Cancer, High Blood Pressure, Diabetes, Ulcers, Kidney Disease, Heart Disease or Lung Disease? □Yes □No ***If yes, please circle***

Allergies to medications, anesthetics or X-Ray dyes? □Yes □ No

• **Please list any medications, dyes or anesthetics that you are allergic to**

Have you had any

1.Recent infection? □Yes □ No
2.Recent immunization? □ Yes □ No
3. Recent foreign travel? □ Yes □ No

List your current Medications:

Medications	**Dosage**

Name: **Date:**

Family History:

	Alive	Age(s)	Dead	Age death	Cause death	Other significant diseases in family
Father						
Mother						
Sibling(s)						
Children						

Social History: Please circle one within the ( ).

- Education: (Lower than Grade school - Grade school - Middle school - High school - College - Graduate school)
- Marital Status: (Single - Married - Widow(er) - Divorced)
- Currently employed: (Y N) If yes, Occupation:_____
- Do you currently smoke? (Y N) If yes, _____Pack(s)/day. How long?_____
- Did you previously smoke? (Y N) If yes, _____Pack(s)/day. How long?_____
- How often do you drink alcoholic beverages? (Never - Occasionally - Frequently)
- Have you abused any drug? (Y N) (Cocaine Crack LSD Marijuana Heroin Prescription drug Recreational drug)
- Is there a lawsuit planned relating to your medical problem/injury? (Y N)
  If yes, against whom?_____ Attorney: _____
- Worker's Compensation case? (Y N) Employer: _____

****My signature signifies that I have read, answered, and understand the above information.****

Patient/Guardian signature: _____Date:_____

Physician's Comments:

H & P Dictated Date:

CC:

1.
2.
3.
4.

Other Comments:

_____

_____

_____

_____

_____