Neurology Associates of Westchester, PLLC.
19 Bradhurst Avenue   Suite 2850
Hawthorne, NY 10532 Tel #: 914-345-1313 Fax # 914-345-5004

You have an appointment with your Neurologist __________. Please complete the following information and bring with you at time of appointment. There will be a fee charged for an appointment that is not cancelled at least 24 hours in advance. If you are a non-English speaking patient, you must bring a translator to all appointments. Complete these documents in advance or you must arrive 20 early.

Last Name:__________________ **First Name**:______________________ **Sex**:_____**Age**: ____
DOB: _______________________ **Marital Status:** _____________________

Referring Physician: ________________________________ **Tel:** _______________________
Address: ____ **Fax**: ______________________
____
(Must include this information so we can send consult note to your physician!)
Please list all other doctors that you are seeing including address and telephone numbers
____

Chief Complaint: ____

MEDICATIONS	Dose	Start	Stop	Response	Side Effects

Over the Counter or Alternative Medicines (vitamins, herbs, etc.) ______________________

Past Medical History (Please circle)

Hypertension	Diabetes	Elevated Cholesterol
Malignancy/Tumor	Trauma	Thyroid Disease
AIDS/ HIV	Colon	Cancer
Heart Disease	Hepatitis	

Please list any allergies to medications, environment, food or others: ____________________________
Surgical History: ____

Hospitalizations: ____

SIGNATURE: ____

DATE COMPLETED: ________________________________
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Last name: ________________________ First name: _______________ DOB: ________

Family History: Please comment on the health of:

Members	Status (alive or dead)	DOB/ AGE	Diabetic	Hypertension	Heart	Stroke	Mental Illness	Cancer	Unknown
Mother									
Father									
Siblings									
Son(s)									
Daughter(s)									

Siblings #: Brothers: _______ Sisters: _______
Children #: Sons: _______ Daughters: ______

Personal/Social History:

Tobacco: Current smoker __________, Former smoker ___________, Non-smoker _________
Recreational Drug Use: Yes_________ Frequency________ No _______________
Alcohol: Has Alcohol been consumed within the last year? Yes____ No _____________
Recent travel (Outside of Continental USA): ________________________ (location)

Describe any Sleep problems: ____

Review of Systems: Height: ________ Weight: __________

COMPLAINTS: Yes/No

Weight loss: _______ Constipation: _________ Skin Lesion (s): ________
Auto Inmune: ______ Urinary incontinence: ____ Auditory Hallucinations:____
Double Vision: ______ Easy Bruising: ________ Visual Hallucinations: _____
Difficulty Swallowing:_____ Painful Joints: ______ Pain in Neck: ____________
Cold intolerance: _________ Ankle Swelling:_______ Pain in Back: ____________
Shortness of Breath: ______ Memory Loss:_________ Change is taste/smell: _____
Palpitations: ________ Headaches: ___________ Walking/ Gait:____________

Indicate which studies have been done so far include date/results and copies of reports!

Study	Date	Results
CT		
MRI		
EEG		
EMG/NCV		
Lumbar Puncture (spinal Tap)		
Duplex/Ultrasound of carotid arteries		
Evoked Potential Test		
Holter Monitor or EKG		
Transcranial Doppler		
Echocardiogram		
Sleep Studies		

You can discuss my healthcare with: ______________________ (relationship) ___________
DO not discuss my healthcare with: _________________________________ (Leave blank if not applicable).