

GREATER PITTSBURGH NEUROLOGY CONSULTANTS

Patient Name _____ Age _____ Date _____

In order to provide you with the best possible neurological care, we will need you to complete the following. If you are currently experiencing any of these problems, please circle the symptoms or NONE if appropriate. *Thank you.*

CONSTITUTIONAL SYMPTOMS

Fever
Weight Loss
Lack of Energy
Trouble Sleeping
Headaches
Other (explain)
NONE

EYES

Pain
Blurred Vision
Loss of Vision
Double Vision
Other (explain)
NONE

CARDIOVASCULAR

Chest Pain
Shortness of Breath
Palpitations
Other (explain)
NONE

RESPIRATORY

Cough
Coughing Blood
Coughing Mucus
Other (explain)
NONE

GASTROINTESTINAL

Abdominal Pain
Frequent Nausea
Diarrhea
Rectal Bleeding
Jaundice
Other (explain)
NONE

GENITOURINARY

Urination Frequency or Urgency
Blood in Urine
Trouble Urinating
Other (explain)
NONE

MUSCULOSKELETAL

Muscle Cramping or Pain
Weakness
Joint Pains
Joint Swelling
Other (explain)
NONE

INTEGUMENTARY (SKIN)

Rashes
Other (explain)
NONE

ENDOCRINE

Diabetes
Thyroid Disease
Other (explain)
NONE

PSYCHIATRIC

Depression
Anxiety
Hallucinations
Other (explain)
NONE

HEMATOLOGIC/LYMPHATIC

Abnormal Bleeding
Anemia
Swollen Glands
Other (explain)
NONE

ALLERGIC/IMMUNOLOGIC

Drugs (please list)
Hayfever
Other (explain)
NONE

FEMALES - ONLY

Menstrual Irregularities
Breast Mass
Breast Discharge
Breast Pain
Other (explain)
NONE

Have you had any surgeries? NO YES If yes, please list type(s) and date(s): _____