

NEURO-ONCOLOGY ASSOCIATES

Karen Fink, M.D., Ph.D. • Vanessa Nestor, M.S., APRN, FNP-C

3600 Gaston Avenue, Barnett Tower Suite 605 • Dallas, Texas 75246 • Phone 214-820-8690 • Fax 214-820-8691

Today's Date: _____

Patient Name: _____ Age: _____ Date of Birth: _____

Main Reason for Visit: _____

Allergies to Medications (describe type of reaction or side effect): _____

PAST MEDICAL HISTORY:

- Y N High blood pressure
- Y N Diabetes
- Y N High Cholesterol/Lipids
- Y N Thyroid Disease
- Y N Heart Disease
- Y N Cancer, Tumor, Malignancy
- Y N Stroke or TIA
- Y N Diagnosis of Epilepsy or Seizures
- Y N Treatment by Psychiatrist or Counselor
- Y N Other: _____
- Y N Other: _____
- Y N Other: _____

PAST SURGERIES:

- Y N Brain surgery: Tumor type _____
- Y N Neck or back surgery (circle)
- Y N Sinus, facial or dental surgery (circle)
- Y N Vascular surgery
- Y N Heart or lung surgery (circle)
- Y N Abdominal surgery
- Y N Hysterectomy, tubal ligation, C-section (circle)
- Y N Other: _____

INJURIES:

- Y N Head injury
- Y N Spinal injury
- Y N Hand, leg, arm or foot injury (circle)
- Y N Other injuries, fractures: _____

FAMILY MEDICAL HISTORY:

Family Member	Alive or Deceased (Circle One)	Age (Current or at Time of Death)	Health Status or Cause of Death
Grandmother (Mom's)	A D		
Grandfather (Mom's)	A D		
Grandmother (Dad's)	A D		
Grandfather (Dad's)	A D		
Mother	A D		
Father	A D		
Sister/Brother (circle one)	A D		
Sister/Brother (circle one)	A D		

Is there a history of the following in your family? If so, please list family member(s):

Y N Brain Tumor _____	Y N Hypertension _____
Y N Cancer _____	Y N Migraine Headaches _____
Y N Neurofibromatosis _____	Y N Diabetes _____
Y N Stroke _____	Y N Epilepsy _____
Y N Tremors _____	Y N Heart Disease _____
Y N Alzheimer's _____	

OTHER HISTORY:

Occupation: _____ [] Retired (year): _____

Highest level of school: _____

Work Status: [] Full-time [] Part-time [] Unemployed [] Disabled: Short-term/Long-term

Marital Status: [] Single [] Married [] Divorced [] Widowed

Do you have children: [] No [] Yes How many? _____ Ages _____

Who lives with you at home? _____

Tobacco Use: [] Never [] Yes (see below) [] Quit (see below)

Start (year): _____ Quit (year): _____

Type: [] Cigarette: Packs per day _____ [] Pipe [] Snuff [] Cigar []

Chew

Do you drink alcohol? [] No [] Yes How Much? _____

Do you exercise regularly? [] No [] Yes Times per week: _____ Type: _____

Have you been exposed to HIV? [] Don't know [] No [] Yes

Have you ever received a blood transfusion? [] No [] Yes Date of transfusion: _____

Have you been exposed to toxins? [] Don't know [] No [] Yes Type: _____

REVIEW OF SYSTEMS: Have you experienced the following symptoms during the last year?

Constitutional

Fever (constant) Y N
 Weight Loss Y N
 Weight Gain Y N
 Blackouts Y N
 Dizziness Y N
 Excessive Fatigue Y N
 Change in Appetite Y N

Hot Flashes Y N
 Chills Y N
 Night Sweats Y N
 Other:

Gastrointestinal

Choking on Food/Liquids Y N
 Diarrhea Y N
 Constipation Y N
 Nausea Y N
 Heartburn Y N
 Vomiting Y N
 Abdominal Pain Y N
 Bowel Incontinence Y N
 Other:

Genitourinary

Urinary Tract Infections Y N
 Painful Urination Y N
 Blood In Your Urine Y N
 Incontinence Y N
 Frequent Urination Y N
 Other: Y N

Musculoskeletal

Muscle Weakness Y N
 Back Pain Y N
 Muscle Pain Y N
 Joint Stiffness/pain Y N
 Other:

**Hematological/
Lymphatic**

Swollen Glands Y N
 Easy Bruising Y N
 Easy Bleeding Y N
 Other:

Neurological

Seizures Y N
 Problems with Memory Y N
 Disorientation / Confusion Y N
 Poor Balance Y N
 Speech Changes Y N
 Headaches Y N
 Tremors Y N
 Blackout/Loss of consciousness Y N
 Double Vision Y N
 Tingling Y N
 Weakness Y N
 Numbness Y N
 Other:

Cardiovascular

Chest Pain Y N
 Waking up Short of Breath Y N
 Short of Breath Lying Flat Y N
 Leg Swelling Y N
 Irregular Pulse Y N
 Heart Murmur Y N
 Other:

Psychiatric

Anxiety Y N
 Mood Swings Y N
 Hallucinations Y N
 Hyperactivity Y N
 Irritability Y N
 Depression Y N
 High Stress Y N
 Other:

Endocrine

Excessive Thirst Y N
 Heat Intolerance Y N
 Cold Intolerance Y N
 High Blood Pressure Y N
 Low Blood Pressure Y N
 Other:

Ear, Nose, Throat, & Mouth

Wearing Hearing Aids Y N
 Hearing Loss Y N
 Change in Smell Y N
 Sinus Pain Y N
 Sore Throat Y N
 Ringing Ears Y N
 Nasal Congestion Y N
 Nose Bleed Y N
 Nasal Drainage Y N
 Change in Taste Y N
 Ear Pain Y N
 Hoarseness Y N
 Other:

Skin/Breast

Easy Bruising Y N
 Hair Loss Y N
 Nail Changes Y N
 Hives Y N
 Rash Y N
 Acne Y N
 Itching Y N
 Other:

Eyes/Head

Eye Pain Y N
 Vision Changes Y N
 Watery Eyes Y N
 Itchy Eyes Y N
 Other:

Respiratory

Wheezing Y N
 Chronic Cough Y N
 Chest Tightness Y N
 Shortness of breath - at rest Y N
 Shortness of breath –walking Y N
 Coughing blood Y N
 Other:

Allergy/Immunology

Seasonal Allergies Y N
 Frequent Infections Y N
 Other: _____

