NEURO-ONCOLOGY
Associates

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Today's Date: _____

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

Main Reason for Visit:_____

Height:_____ Weight:_____ [ ] Right Handed or [ ] Left Handed

Referring Physician: _____ Phone #: _____ City: _____

Primary Care Physician: _____ Phone #: _____ City: _____

[ ] Please send copies of clinic notes to these physicians. [ ] DO NOT send copies of clinic notes to any other physicians.
Please use the back page to list any other physicians who should receive copies.

When was your last MRI? _____ Where was the MRI performed? _____

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: _____

Current Medications (Drug)	Dose	Frequency (times taken per day)

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 Alzheimer's _____ Y N Hypertension _____

Y N Brain Tumor _____ Y N Migraine Headaches _____

Y N Cancer _____ Y N Multiple Sclerosis _____

Y N Cerebral Palsy _____ Y N Neurofibromatosis _____

Y N Diabetes _____ Y N Stroke _____

Y N Epilepsy _____ Y N Tremors _____

Y N Heart Disease _____ Y N Tuberous Sclerosis _____

OTHER HISTORY:

Occupation: _____ [ ] Retired (year): _____

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? _____

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
Poor Appetite	Y	N
Hot Flashes	Y	N
Chills	Y	N
Night Sweats	Y	N
Other: _____	Y	N

Gastrointestinal

Indigestion – Pain w/Eating	Y	N
Choking on Food	Y	N
Diarrhea	Y	N
Nausea	Y	N
Heartburn	Y	N
Constipation	Y	N
Vomiting	Y	N
Blood in your Vomit	Y	N
Abdominal Pain	Y	N
Bowel Incontinence	Y	N
Other: _____		

Genitourinary Y N

Urinary Tract Infections	Y	N
Painful Urination	Y	N
Blood In Your Urine	Y	N
Incontinence	Y	N
Frequent Urination	Y	N
Urination at Night	Y	N
Decreased Urine Flow	Y	N
Abnormal Periods	Y	N
Vaginal Discharge	Y	N
Other: _____		

Musculoskeletal

Muscle Weakness	Y	N
Back Pain	Y	N
Muscle Pain	Y	N
Joint Stiffness	Y	N
Joint Pain	Y	N
Arthritis	Y	N
Other: _____		

Hematological/Lymphatic

Anemia	Y	N
Hemophilia	Y	N
Swollen Glands	Y	N
Sickle Cell Disease	Y	N
Easy Bruising	Y	N
Easy Bleeding	Y	N
Other: _____		

Neurological

Seizures/Epilespsy	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
Lack of Concentration	Y	N
Double or Blurred Vision	Y	N
Tingling	Y	N
Paralysis	Y	N
Numbness	Y	N
Other: _____		

Cardiovascular

Chest Pain or Angina	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
Heart Skipping	Y	N
Heart Fluttering	Y	N
Other: _____		

Psychiatric

Anxiety	Y	N
Mood Swings	Y	N
Hallucinations	Y	N
Hyperactive	Y	N
Irritable	Y	N
Depression	Y	N
High Stress	Y	N
Other: _____		

Allergy / Immunology

Nasal Drainage	Y	N
Frequent Infections	Y	N
Allergy Shots	Y	N
Autoimmune Disease	Y	N
Seasonal Allergies	Y	N
Frequent Colds	Y	N
Other: _____		

Endocrine

Excessive Thirst	Y	N
Heat Intolerance	Y	N
Frequent Urination	Y	N
Cold Intolerance	Y	N
Increased Appetite	Y	N
Diabetes	Y	N
Thyroid Disease	Y	N
Other: _____		

Ear, Nose, Throat, & Mouth

Wearing Hearing Aids	Y	N
Hearing Loss	Y	N
Balance Disturbance	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
Hoarseness	Y	N
Change in Taste	Y	N
Ear Pain	Y	N
Nasal Drainage	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
Breast Lump	Y	N
Nipple Discharge	Y	N
Other: _____		

Eyes/Head

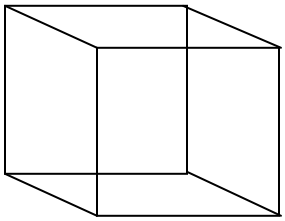
Glaucoma	Y	N
Eye Pain	Y	N
Vision Changes	Y	N
Double Vision	Y	N
Seeing Spots	Y	N
Watery Eyes	Y	N
Itchy Eyes	Y	N
Headaches	Y	N
Other: _____		

Respiratory

Asthma	Y	N
Chronic Cough	Y	N
Chest Tightness	Y	N
Emphysema	Y	N
Shortness of breath - at rest	Y	N
Shortness of breath - walking	Y	N
Bronchitis	Y	N
Pneumonia	Y	N
Lung Cancer	Y	N
Coughing Blood	Y	N
Other: _____		

PRE-EXAM EXERCISES:

1. Please draw a copy of this cube in the space below:



2. Please draw a clock:

3. Please write a sentence here:

Current Medications (Drug)	Dose	Frequency (times taken per day)

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