NEURO-ONCOLOGY
Associates

Karen Fink, M.D., Ph.D. - Isaac Melguizo-Gavilanes, M.D.
Vanessa Nestor, DNP, APRN, FNP-C

3410 Worth Street, Suite 820 • Dallas, Texas 75246 • Phone 214-820-8690 • Fax 214-820-8691

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 (Please choose one)

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

PAST SURGERIES:

Y N (Please choose one)

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

INJURIES:

Y N (Please choose one)

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

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

FAMILY MEDICAL HISTORY:

Family Member	Check Box if Alive	Age (Current or at Time of Death)	Health Status or Cause of Death
Grandmother (Mom's)			
Grandfather (Mom's)			
Grandmother (Dad's)			
Grandfather (Dad's)			
Mother			
Father			
Sister/Brother (circle one)			
Sister/Brother (circle one)			

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

Y N (Please choose one) Y N (Please choose one)

Alzheimers _____ Hypertension _____

Brain Tumor _____ Migraine Headaches___

Cancer _____ Multiple Sclerosis_____

Cerebral Palsy _____ Neurofibromatosis ____

Diabetes _____ Stroke_____

Epilepsy _____ Tremors _____

Heart Disease 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?

Please choose yes or no for each response.

Constitutional	Y N
Fever (constant)	
Weight Loss	
Weight Gain	
Blackouts	
Dizziness	
Excessive Fatigue	
Poor Appetite	
Hot Flashes	
Chills	
Night Sweats	
Other: _____	

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

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

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

Hematological/Lymphatic	Y N
Anemia	
Hemophilia	
Swollen Glands	
Sickle Cell Disease	
Easy Bruising	
Easy Bleeding	
Other:	

Neurological	Y N
Seizures/Epilespsy	
Problems with Memory	
Disorientation / Confusion	
Poor Balance	
Speech Changes	
Headaches	
Tremors	
Lack of Concentration	
Double or Blurred Vision	
Tingling	
Paralysis	
Numbness	
Other: _____	

Cardiovascular	Y N
Chest Pain or Angina	
Waking up Short of Breath	
Short of Breath Lying Flat	
Leg Swelling	
Irregular Pulse	
Heart Murmur	
Heart Skipping	
Heart Fluttering	
Other: _____	

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

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

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

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

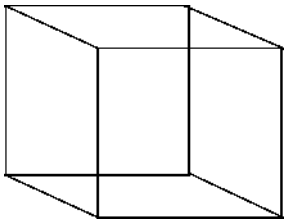
Skin/Breast	Y N
Easy Bruising	
Hair Loss	
Nail Changes	
Hives	
Rash	
Acne	
Itching	
Breast Lump	
Nipple Discharge	
Other: _____	

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

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

PRE-EXAM EXERCISES: (NEW PATIENTS: Please print this page off and complete the first three boxes)

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



0. Please draw a clock:

1. Please write a sentence here:

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

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