

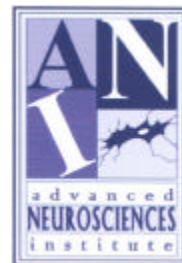
Advanced Neurosciences Institute

CURRENT MEDICAL INFORMATION

Neurology

Instructions: Complete the following information by checking the appropriate box or printing information.

Please do not write in the areas labeled "Reviewer's Comments."



Last name:
First name:
Date of Birth:
Social Security:

Review of Systems Please check "yes" or "no" to the following as related to your current visit.

Reviewer to elaborate where appropriate.

Have you had (please check item):	Yes	No	Reviewer's Comments
Any reactions to <input type="checkbox"/> foods, <input type="checkbox"/> molds, <input type="checkbox"/> dust or <input type="checkbox"/> bee stings?	<input type="checkbox"/>	<input type="checkbox"/>	Immune:
A <input type="checkbox"/> fever, <input type="checkbox"/> sore tongue, or <input type="checkbox"/> mouth sores in the last month?	<input type="checkbox"/>	<input type="checkbox"/>	Constitution:
A change in weight <input type="checkbox"/> up/ <input type="checkbox"/> down more than 10 lbs. in the last 6 mos?	<input type="checkbox"/>	<input type="checkbox"/>	
Any <input type="checkbox"/> enlarged glands, <input type="checkbox"/> goiter or <input type="checkbox"/> lymph nodes:	<input type="checkbox"/>	<input type="checkbox"/>	Heme:
<input type="checkbox"/> blood clotting disorder, frequent bleeding <input type="checkbox"/> gums/ <input type="checkbox"/> nose or <input type="checkbox"/> bruising?	<input type="checkbox"/>	<input type="checkbox"/>	
A <input type="checkbox"/> skin rash, <input type="checkbox"/> sores, <input type="checkbox"/> breast lumps or <input type="checkbox"/> changing moles?	<input type="checkbox"/>	<input type="checkbox"/>	Integument:
Noticed a recent change in your <input type="checkbox"/> skin or <input type="checkbox"/> hair texture?	<input type="checkbox"/>	<input type="checkbox"/>	
Great difficulty with feeling <input type="checkbox"/> hot/ <input type="checkbox"/> cold when others are comfortable?	<input type="checkbox"/>	<input type="checkbox"/>	Endocrine:
Excessive <input type="checkbox"/> urination and <input type="checkbox"/> thirst? When? _____	<input type="checkbox"/>	<input type="checkbox"/>	
A problem with <input type="checkbox"/> disabling pain or <input type="checkbox"/> fatigue? Where? _____	<input type="checkbox"/>	<input type="checkbox"/>	Musculoskel.:
<input type="checkbox"/> Pain or <input type="checkbox"/> stiffness in your <input type="checkbox"/> joints (which: _____) or <input type="checkbox"/> back?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Double vision or <input type="checkbox"/> blurred vision? <input type="checkbox"/> Glasses? <input type="checkbox"/> Lazy or crossed eye?	<input type="checkbox"/>	<input type="checkbox"/>	Neuro:
Problems with <input type="checkbox"/> falling/ <input type="checkbox"/> staying asleep or being <input type="checkbox"/> too sleepy?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Severe/ <input type="checkbox"/> frequent headaches? <input type="checkbox"/> Funny sensations or <input type="checkbox"/> numbness?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Fainting, <input type="checkbox"/> falling, other <input type="checkbox"/> unusual spells, <input type="checkbox"/> seizures, or <input type="checkbox"/> convulsions?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with <input type="checkbox"/> slurred speech or <input type="checkbox"/> weak/ <input type="checkbox"/> clumsy <input type="checkbox"/> arm/ <input type="checkbox"/> leg?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Tremors, <input type="checkbox"/> jerks, <input type="checkbox"/> cramps, or <input type="checkbox"/> other abnormal movements?	<input type="checkbox"/>	<input type="checkbox"/>	
Marked difficulty with <input type="checkbox"/> memory, <input type="checkbox"/> confusion, or <input type="checkbox"/> expressing yourself?	<input type="checkbox"/>	<input type="checkbox"/>	Psych:
Feel <input type="checkbox"/> stressed, <input type="checkbox"/> depressed, <input type="checkbox"/> tired, or <input type="checkbox"/> nervous frequently?	<input type="checkbox"/>	<input type="checkbox"/>	
Problem <input type="checkbox"/> hearing, <input type="checkbox"/> dizziness, <input type="checkbox"/> hoarseness or with <input type="checkbox"/> sinuses?	<input type="checkbox"/>	<input type="checkbox"/>	ENT:
Difficulty <input type="checkbox"/> eating, <input type="checkbox"/> drinking, <input type="checkbox"/> chewing, <input type="checkbox"/> choking or <input type="checkbox"/> swallowing?	<input type="checkbox"/>	<input type="checkbox"/>	
Chest <input type="checkbox"/> pain/ <input type="checkbox"/> pressure, abnormal <input type="checkbox"/> heart beat, <input type="checkbox"/> valve, or <input type="checkbox"/> murmur?	<input type="checkbox"/>	<input type="checkbox"/>	Vascular:
Shortness of breath <input type="checkbox"/> at night or <input type="checkbox"/> with only a little activity?	<input type="checkbox"/>	<input type="checkbox"/>	
Abnormal swelling of your <input type="checkbox"/> ankles or <input type="checkbox"/> feet? <input type="checkbox"/> Calf pain when walking?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Asthma, <input type="checkbox"/> wheezing, or <input type="checkbox"/> coughing up <input type="checkbox"/> sputum or <input type="checkbox"/> blood?	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory:
<input type="checkbox"/> Indigestion, <input type="checkbox"/> heartburn, <input type="checkbox"/> nausea, <input type="checkbox"/> vomiting, or <input type="checkbox"/> stomach ulcers?	<input type="checkbox"/>	<input type="checkbox"/>	Gastrointestinal:
<input type="checkbox"/> Constipation, <input type="checkbox"/> diarrhea, or <input type="checkbox"/> blood/ <input type="checkbox"/> changes in bowel movements?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Burning or <input type="checkbox"/> pain when urinating or <input type="checkbox"/> bloody urine?	<input type="checkbox"/>	<input type="checkbox"/>	Urinary:
Difficulty with <input type="checkbox"/> starting urine, <input type="checkbox"/> emptying bladder, or <input type="checkbox"/> leaking urine?	<input type="checkbox"/>	<input type="checkbox"/>	
Difficulty with your sexual function?	<input type="checkbox"/>	<input type="checkbox"/>	
Women only:			Gyne:
A <input type="checkbox"/> mammogram, <input type="checkbox"/> Pap smear, and <input type="checkbox"/> pelvic examination in the last year?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> irregular menstrual periods or <input type="checkbox"/> recent abnormal vaginal discharge?	<input type="checkbox"/>	<input type="checkbox"/>	
Might you be pregnant at this time?	<input type="checkbox"/>	<input type="checkbox"/>	LMP:

Health Care Provider Review - I have reviewed this form with the patient:

Provider Signature No. Date Provider Signature No. Date