Baylor Scott & White
NEUROLOGY AT DALLAS
A Baylor Scott & White Health - HealthTexas Affiliate

New Patient Packet

Patient Name: _____ DOB: _____ Age: _____

Sex: Male / Female Height: _____ Weight: _____

PHYSICIAN CARE

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Referring Physician (if different from PCP): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PHARMACIES

Primary Pharmacy Type: □ Local □ Mail-Order □ Specialty

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PATIENT HISTORY

Reason for visit – Chief Complaint (History of Present Illness)

Please describe the major problem that brings you in today to see a Neurologist:

_____

_____

_____

_____

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Past Medical History Have you ever been diagnosed with any of the following medical conditions ? Please list any other conditions not listed in the space below.

YES	*NO*	*Condition*	*MONTH/YEAR*
		Anemia	
		Asthma	
		Arthritis, which joints mostly?	
		Atrial Fibrillation	
		Bipolar Disorder	
		Cancer, What type (s):	
		Cataracts	
		Cerebral Palsy	
		Chronic Obstructive Pulmonary Disease (COPD)	
		Chronic Kidney Disease	
		Coronary Artery (Heart) Disease	
		Congestive Heart Failure	
		Chronic Liver Failure	
		Concussion	
		Depression	
		Diabetes	
		Epilepsy / Seizures	
		Fibromyalgia	
		Glaucoma	
		Gastric Ulcers	
		Headaches / Migraines	
		High Blood Pressure	
		High Cholesterol	
		HIV	
		Lupus	
		Memory Difficulties	
		Miscarriages	
		Multiple Sclerosis	
		Myasthenia Gravis	
		Parkinson Disease	
		Stroke (Cerebrovascular Accident)	
		Spinal Cord Injury	
		Traumatic Brain Injury	
Yes	No	Other (please specify):	

Name:_____ DOB:_____ Date_____

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Surgical History Have you had any of the following surgical procedures? Please list any other surgeries not listed in the space below.

YES	*NO*	*SURGERY TYPE*	*DATE/MONTH/YEAR*
		Appendectomy	
		Brain Surgery	
		Breast Surgery	
		CABG (open heart surgery)	
		Colon Surgery	
		Cosmetic Surgery	
		C-Section	
		Eye Surgery	
		Fracture (bone) Surgery	
		Hernia Repair	
		Hysterectomy	
		Joint Replacement (knee, hip, etc.)	
		Small Intestine Surgery	
		Spine Surgery	
		Tubal Ligation	
		Vasectomy	
		Valve Replacement	
		Other (please specify):	

Allergies

Please list your Allergies and Reactions to any Foods, Drugs, Radiology Dyes, and Allergy Triggers resulting from a Chronic Condition.

*(**Ex. "Allergic to:** Eggs, Penicillin, Sulfas, Iodine, Local Anesthetics (Lidocaine), Latex, Contrast, Perfume, Smoke")*

***(Ex. "Reactions:** Hives, Shortness of Breath, Trouble Breathing/Wheezing, and Anaphylaxis")*

Allergic to: _____ Reactions: _____

Allergic to: _____ Reactions: _____

Allergic to: _____ Reactions: _____

Allergic to: _____ Reactions: _____

Allergic to: _____ Reactions: _____

Females: Are you, or could you be pregnant? (Circle one) Yes / No

Last menstrual period _____ Ever use Oral Contraceptives? _____

Ever used Hormone Replacement Therapy? _____

Name:_____ DOB:_____ Date_____

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CURRENT MEDICATION LOG

List any medication or over the counter/herbal supplements you are currently taking:

Medication	Start Date	Dose/Frequency	Prescribing Physician	Comments

Please List any over the counter medications, supplements, herbal treatments, or alternative medications that you may be taking:

Name:_____ DOB:_____ Date_____

Social History:

Occupation: _____ Marital Status: _____ Number of children: _____
Hobbies: _____
Do you smoke cigarettes? _____ If so, how many packs a day? _____
At what age did you start? _____ If applicable, at what age did you stop? _____
Do you drink alcohol? _____ If yes, how much daily? _____
At what age did you start? _____ If applicable, at what age did you stop? _____
Do you use recreational drugs? _____ Type? _____
Do you exercise regularly? (Circle one) No Yes How frequently? _____

Family History: Does anyone in your family have any of the following Medical Conditions, please indicate who.

Memory Difficulty:	NO	YES	Family Member: _____
Seizures:	NO	YES	Family Member: _____
Stroke:	NO	YES	Family Member: _____
Parkinson's disease:	NO	YES	Family Member: _____
Multiple Sclerosis:	NO	YES	Family Member: _____
Cancers:	NO	YES	Family Member: _____
			Type of Cancer: _____
Diabetes	NO	YES	Family Member: _____
Heart Disease	NO	YES	Family Member / what age:_____

Others: → Family Member: _____
Medical Condition: _____

Name:_____ DOB:_____ Date_____

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Review of Symptoms/Chronic Conditions Do you currently, or have you had a problem with:

Constitutional:	***Circle One***
Fever	Yes No
Unexplained weight loss >10 lbs.	Yes No
Excessive fatigue	Yes No
History of Falls	Yes No
Eyes:	
Wear glasses	Yes No
Infections	Yes No
Injuries	Yes No
Ear, Nose, Throat& Mouth:	
Wear hearing aid(s)	Yes No
Hearing loss	Yes No
Ear pain/infections	Yes No
Ringing in ears	Yes No
Nose bleeds	Yes No
Nasal congestion/drainage	Yes No
Inability to smell	Yes No
Sinus problems	Yes No
Balance (vertigo, spinning, etc.)	Yes No
Cardiovascular:	
Chest pain or angina	Yes No
High blood pressure	Yes No
Irregular pulse / Palpitations	Yes No
Heart murmur	Yes No
Swelling in hands or feet	Yes No
Leg pain while walking	Yes No
Respiratory:	
Shortness of breath	Yes No
Bloody sputum	Yes No
Gastrointestinal:	
Nausea	Yes No
Vomiting	Yes No
Blood in your vomit	Yes No
Abdominal pain	Yes No
Change in bowel habits	Yes No
Chronic Pain:	
Back Pain	Yes No
Neck Pain	Yes No
Headache	Yes No
Limb Pain	Yes No
Abdominal Pain	Yes No
Chest Pain	Yes No

Endocrine:	***Circle One***
Diabetes	Yes No
Thyroid disease	Yes No
Excessive thirst/urination	Yes No
Genitourinary:	
Urinary tract infections	Yes No
Painful urination	Yes No
Blood in your urine	Yes No
Difficult starting/stopping stream	Yes No
Incontinence	Yes No
Kidney stones	Yes No
Musculoskeletal:	
Broken bones	Yes No
Arm or leg weakness	Yes No
Arm or leg pain	Yes No
Joint pain or swelling	Yes No
Integumentary:	
Skin disease	Yes No
Breast pain, tenderness, nipple discharge	Yes No
Unusual moles-birthmarks	Yes No
Rash	Yes No
Neurological:	
Fainting spells or “black outs”	Yes No
Problems with memory	Yes No
Disorientation	Yes No
Difficulty with speech	Yes No
Inability to concentrate	Yes No
Double or blurred vision	Yes No
Weakness in arms and/or legs	Yes No
Loss of sensation	Yes No
Difficulty with balance	Yes No
Psychiatric:	
Anxiety	Yes No
Depression	Yes No
Hematologic/Lymphatic:	
Bleeding problems	Yes No
Blood transfusion	Yes No
Persistent swollen glands/lymph nodes	Yes No
Allergic/Immunologic:	
Food, Inhalant (nasal) allergies	Yes No

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Chronic Pain Patients

Please identify any therapy treatment used in the past:

PREVIOUS TREATMENTS FOR PAIN:	TREATMENT	HELPFUL?	CURRENT/ONGOING	COMMENTS
Tens Unit?	□ Y □ N	□ Y □ N	□ Y □ N	
Physical/Occupational Therapy?	□ Y □ N	□ Y □ N	□ Y □ N	
Psychological Evaluation?	□ Y □ N	□ Y □ N	□ Y □ N	Who:
Chiropractic Treatment?	□ Y □ N	□ Y □ N	□ Y □ N	Who:
Nerve Blocks?	□ Y □ N	□ Y □ N	□ Y □ N	Who:
Epidural Injections	□ Y □ N	□ Y □ N	□ Y □ N	Who:
Surgeries?	□ Y □ N	□ Y □ N	Type:	

Name:_____ DOB:_____ Date_____