PMSI Division of Neurology
1569 Medical Drive, Suite 201
Pottstown, PA 19464

New Patient Encounter Form

Name _____

Handedness (circle one): Right handed / Left Handed / Ambidextrous

What symptoms or diagnosis prompted this referral to see a neurologist?
_____
_____
_____

Medications you currently take? (Or provide a list to the receptionist)
_____
_____

Birth Control Pills: No Yes
Aspirin: No Yes
Vitamins No Yes

Over-the-counter (non-prescription) medications:
_____
_____

Allergies to medicines/injections: No Yes If yes, please list: _____

Have you ever been treated for: (circle yes or no)

Diabetes Mellitus	No Yes	Depression	No Yes
High Blood Pressure	No Yes	Anxiety	No Yes
Elevated cholesterol	No Yes	Peptic Ulcers	No Yes
Heart Attack (MI)	No Yes	Asthma	No Yes

List other past or current medical diagnoses:
_____
_____

List hospitalizations/surgeries: _____

Systemic Review: Do you have problems with the following? If yes, please explain.

Feeling tired (fatigue): No Yes _____

Fever: No Yes_____

Recent weight loss: No Yes_____

Vision Problems: No Yes_____

Loss of hearing: No Yes_____

Nasal passage blockage: No Yes_____

Hoarseness: No Yes_____

Sore Throat: No Yes_____

Chest pain or Discomfort: No Yes_____

Difficulty Breathing: No Yes_____

Cough: No Yes_____

Abdominal Pain: No Yes_____

Pain during urination: No Yes_____

Feelings of Weakness: No Yes_____

Muscle aches: No Yes_____

Joint pain: No Yes_____

Numbness: No Yes_____

Have you ever had psychiatric are? No Yes
Have you ever been advised to seek psychiatric care? No Yes

For female patients: Number of children ____ Number of pregnancies _____ Number of miscarriages _____

SOCIAL HISTORY:

Circle one: Single Married Partnered Separated Divorced Widowed Do you live alone? Yes or No

Current job/career: _____

How much alcohol do you consume? _____

Current tobacco use? _____ packs per day.

Were you ever a heavy drinker? No Yes

Do you use street drugs? No Yes

Were you ever a smoker? No Yes

Family History:

Have you used street drugs? No Yes

Have any blood relatives had:

IF yes, which relation?

Heart Attack No Yes _____

Breast Cancer No Yes _____

Colon Cancer No Yes _____

Alzheimer's No Yes _____

Diabetes No Yes _____

Seizures No Yes _____

High blood pressure No Yes _____

Lung Cancer No Yes _____

Migraine No Yes _____

Multiple Sclerosis No Yes _____

Stroke No Yes _____

RELATIVE	If alive: Age?	If Deceased: Age at death and cause of death?	Medical Illnesses
Father			
Mother			
Brothers/Sisters			
Children			