CHESTER NEUROLOGY, PLLC
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PATIENT INFORMATION

TODAY'S DATE: ______________________
LAST NAME: ________________ FIRST NAME: ________________ MIDDLE NAME: _____________
DATE OF BIRTH: ___________________
ADDRESS: ____
SEX: ☐ MALE ☐ FEMALE
TEL: (CHECK THE PREFERRED) _______________________________ HOME ( )
_______________________________ WORK ( )
________________________________ CELL ( )
_____________________ MOBILE PHONE COMPANY (if you wish you receive text messages for appointment reminders)
EMAIL ADDRESS: ________________________________
SS#: ________________________
EMPLOYER: ______________________________
ADDRESS: ____
PHONE NUMBER: _____________________________
EMERGENCY CONTACT NAME: ____________________________
EMERGENCY CONTACT PHONE: ___________________________
PRIMARY PHYSICIAN: ______________________________
ADDRESS:____
PHONE: ____
FAX: ____
EMAIL: ____
REFERRING SOURCE IF OTHER THAN PRIMARY PHYSICIAN: _______________________________

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: ___________________________
SUSCRIBER NAME: _________________________________ DOB: __________________
MEMBER ID # _________________________ GROUP # __________________________
SECONDARY INSURANCE COMPANY: ____________________________
SUSCRIBER NAME: _________________________________ DOB: __________________
MEMBER ID # _________________________ GROUP # __________________________

PHARMACY INFORMATION

PHARMACY NAME: ________________________________
PHARMACY ADDRESS: ______________________________
TELEPHONE # _____________________________________

Name: ____________________________ DOB: _____________________

MEDICAL INTAKE

CHIEF COMPLAINT: _______________________________________

PAST MEDICAL AND SURGICAL HISTORY:

☐DIABETES ☐HYPERTENSION ☐HIGH CHOLESTEROL ☐HEART DISEASE ☐STROKE/TIA

☐EPILEPSY ☐BRAIN INJURY ☐MIGRAINES ☐NECK PAIN ☐LOW BACK PAIN ☐REFLUX

☐ASTHMA ☐COPD ☐DEPRESSION ☐ANXIETY ☐BLOOD CLOTS ☐SLEEPING DISORDERS

OTHER: ____

SURGERIES AND DATES: ____

HOSPITALIZATION HISTORY: _______________________________________

SOCIAL HISTORY:

OCCUPATION: ____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED

CHILDREN: ☐ YES ☐ NO

SMOKING: ☐NEVER ☐QUIT (SPECIFY HOW LONG AGO) ☐CURRENT

ALCOHOL: ☐NEVER ☐SOCIAL ☐ON OCCASIONS ☐FREQUENT

ALLERGIES: _____________________________________

MEDICATIONS WITH DOSAGES AND FREQUENCY:

Name	Dosage	Frequency
1. ____________________	____________________	____________________
2. ____________________	____________________	____________________
3. ____________________	____________________	____________________
4. ____________________	____________________	____________________
5. ____________________	____________________	____________________
6. ____________________	____________________	____________________
7. ____________________	____________________	____________________
8. ____________________	____________________	____________________

Name: ______________________________________ DOB:__________________

FAMILY HISTORY (please check off the condition that is applicable in the family and the relationship).

- ☐ HEART DISEASE ____________
- ☐ HYPERTENSION_______________________
- ☐ DIABETES__________________________
- ☐ HIGH CHOLESTEROL ________________
- ☐ STROKE____________________________
- ☐ CANCER (PLEASE SPECIFY)____________
- ☐ EPILEPSY/SEIZURES__________________
- ☐ ALZEIHMER'S DEMENTIA _____________
- ☐ MIGRAINES______________________
- ☐ DRUG OR ALCOHOL ADDICTION________
- ☐ DEPRESSION/PSYCHOSIS______________
- ☐ MULTIPLE SCLEROSIS_________________
- ☐ LUPUS ___________________
- ☐ RHEUMATOID ARTHRITIS_______
- ☐ OSTEOARTHRITIS_____________________
- ☐ BLOOD CLOTS ______________________
- ☐ PARKINSON'S DISEASE ________________
- ☐ ESSENTIAL TREMORS_________
- ☐ NEUROPATHY_________________________
- ☐ MUSCLE DISEASE_____________
- ☐ OTHER _____________________________

REVIEW OF SYSTEMS

Constitutional: ☐No Problems ☐Fever ☐Chills ☐Night Sweats ☐Dizziness
Other:____

Cardiovascular: ☐No Problems ☐Chest Pain ☐Swelling of Extremities ☐Hypertension
Other:____

Endocrine: ☐No Problems ☐Thyroid Problem ☐Diabetes
Other:____

Eyes: ☐No Problems ☐Blurry Vision ☐Double Vision ☐Itchiness ☐Blindness ☐Photophobia
Other:____

Gastrointestinal: ☐No Problems ☐Nausea ☐Vomiting ☐Bleeding ☐Liver Problem ☐Diarrhea
Other:____

Respiratory: ☐No Problems ☐Asthma ☐Pneumonia ☐Cough ☐Sputum ☐Wheezing
Other:____

Genitourinary: ☐No Problems ☐Bleeding ☐Burning ☐Kidney Stones ☐Prostate Problem
Other:____

Hematologic: No Problems ☐Easy Bruising ☐Anemia ☐Clotting Problem
Other:____

Immunologic: No Problems ☐HIV Positive ☐AIDS
Other:____

Name: ____________________________ DOB:__________________________

Lymphatic: ☐No Problems ☐Nodes ☐Lumps
Other:____

Musculoskeletal: ☐No Problems ☐Pain ☐Swelling ☐Weakness ☐Stiffness Arthritis
Other:____

Neurological: ☐No Problems ☐Numbness ☐Memory Problems ☐Vertigo
Other:____

Ob/Gyn (females only): ☐No Problems ☐Pregnant ☐Irregular Periods ☐Discharge
Other:____

Psychiatric: ☐No Problems ☐Depression ☐Anxiety ☐Hallucinations ☐Suicidal Tendency ☐Drug
AddictionOther:____

Skin: ☐No Problems ☐Rash ☐Lesion ☐Pain
Other:____