**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 SS#: ___________________________________

**TEL: (CHECK THE PREFERRED)** _____________________________________ HOME ( )
_____________________________________ WORK ( )
_____________________________________ CELL ( )

EMAIL ADDRESS: ________________________________________________________
EMERGENCY CONTACT NAME: __________________________________________
EMERGENCY CONTACT PHONE: __________________________________________

### EMPLOYMENT INFORMATION

EMPLOYER'S NAME: ______________________________________________________
ADDRESS: __________________________________________________________________
PHONE NUMBER: _________________________________________________________

ARE YOU HERE FOR A WORK-RELATED INJURY? ( ) YES ( ) NO
ARE YOU HERE FOR A NO FAULT CLAIM? (CAR ACCIDENT) ( ) YES ( ) NO
ARE YOU HERE FOR A MEDICAL MARIJUANA CONSULTATION ( ) YES ( ) NO
**(IF YES TO ANY OF THE ABOVE, PLEASE SPEAK TO THE FRONT DESK STAFF BEFORE PROCEEDING TO THE NEXT PAGE)**

**PRIMARY PHYSICIAN'S INFORMATION**
NAME:________________________________________________________________________
ADDRESS: ___________________________________________________________________
PHONE: _____________________________________________________________________
FAX: _______________________________________________________________________

REFERRING PHYSICIAN'S NAME: ___________________________________________

### PHARMACY INFORMATION

PHARMACY NAME: _____________________________________________________
PHARMACY ADDRESS: __________________________________________________
TELEPHONE # _________________________________________________________

Name: ________________________________ DOB: ________________________

Height:_______ Weight:______

**MEDICAL INTAKE**

**CHIEF COMPLAINT:** ____________________________________________

**PAST MEDICAL AND SURGICAL HISTORY:** (PLEASE CIRCLE ALL THAT APPLIES)

| | | | | | |
|---|---|---|---|---|---|
| HYPERTENSION | NARCOLESPY | DIABETES | EPILEPSY | MIGRAINES | NECK PAIN |
| HYPOTHYROIDISM | REFLUX | COPD | ANXIETY | DEPRESSION | ASTHMA |
| ATRIAL FIBRILLATION | HIGH CHOLESTEROL | LOW BACK PAIN | OBSTRUCTIVE SLEEP APNEA | BRAIN INJURY | HEART DISEASE |
| STROKE/TIA | | | | | |

ANY OTHER MEDICAL CONDITIONS NOT LISTED ABOVE?

______________________________________________________________________________________

SURGERIES AND DATES: ______________________________________________________________________

**SOCIAL HISTORY:**

OCCUPATION: _____________________________________________

| | | | | |
|---|---|---|---|---|
| MARITAL STATUS | SINGLE | MARRIED | DIVORCED | SEPARATED |
| SMOKING | NEVER | QUIT(How Long?) | CURRENT | |
| ALCOHOL | NEVER | SOCIAL | ON OCCASIONS | FREQUENT |

ANY OTHER SUBSTANCE USE?______________________________________________________________

ALLERGIES TO ANY MEDICATIONS? __________________________________________________________

MEDICATIONS

| 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__________________________________
( )ALZHEIMER'S DEMENTIA_________________
( )MIGRAINES________________________________
( )DRUG ADDICTION_________________________
( )ALCOHOL ADDICTION______________________
( )OTHER_____________________________________
( )MULTIPLE SCLEROSIS___________________________
( )LUPUS_______________________________________________
( )RHEUMATOID ARTHRITIS__________________________
( )OSTEOARTHRITIS_________________________________
( )BLOOD CLOTS_____________________________________
( )PARKINSON'S DISEASE___________________________
( )ESSENTIAL TREMORS_____________________________
( )NEUROPATHY_____________________________________
( )MUSCLE DISEASE_________________________________
( )DEPRESSION______________________________________
( )PSYCHOSIS_______________________________________

## REVIEW OF SYSTEMS

**Constitutional:** ☐No problems ☐Weight loss ☐Fever ☐Fatigue ☐Poor appetite ☐Night sweats

**Skin:** ☐No problems ☐Rash ☐Itching ☐Abnormal hair growth ☐Lumps under skin

**Eyes:**☐No problems ☐Pain in the eye ☐Red eye ☐Double vision ☐Cataracts☐Decreased vision☐Sensitivity to light ☐Dry Eyes

**Ears:** ☐No problems ☐Ear Ache ☐Decreased hearing ☐Vertigo ☐Loss of balance

**Nose:** ☐No problems ☐Stuffy nose ☐Pain over sinuses ☐Bleeding from nose ☐Loss of smell sense ☐Runny nose

**Throat:** ☐No problems ☐Sore throat ☐Ulcers inside mouth ☐Swelling of tongue ☐Difficulty swallowing ☐Dry mouth

**Neck:** ☐No problems ☐Lumps in neck ☐Painful glands in the neck ☐Pain on turning the neck ☐Stiff neck

**Heart:** ☐No problems ☐Chest Pain ☐Chest Tightness ☐Palpitations

**Lungs:** ☐No problems ☐Cough ☐Excessive snoring ☐Wheezing ☐Asthma ☐Chest congestion ☐shortness of breath

**Abdomen:** ☐No Problems ☐Nausea ☐Vomiting ☐Abdominal pain ☐Diarrhea ☐Blood in stool ☐ constipation

**Musculoskeletal**: ☐No Problems ☐Joint pains ☐Morning stiffness ☐Joint swelling ☐Low back pain
☐Pain in hands ☐Muscle spasm

**Urinary System:** ☐No problems ☐Difficulty in urinating ☐Burning in urination ☐Frequent urination ☐Incontinence ☐Blood in urine
☐Kidney stones

**Hematologic**: ☐No problems ☐Anemia ☐Easy bruising ☐Frequent nose bleeds ☐Blood clots

**Neurologic:** ☐No problems ☐Dizziness ☐Fainting ☐Seizures ☐Weakness ☐Numbness ☐Tingling ☐Tremors ☐Headaches
☐Falls ☐Unsteady gait ☐Clumsiness of hands ☐Slurred speech ☐Loss of speech ☐Confusion ☐Burning feet

**Psychiatric:** ☐No problems ☐Depression ☐Poor concentration ☐Anxiety ☐Poor memory ☐Hallucinations ☐Paranoia
☐Suicidal thoughts ☐Panic attacks

**Endocrine:** ☐No problems ☐Cold Intolerance ☐Heat Intolerance ☐Increased Thirst

**Allergy / Immuno**: ☐No problems ☐Hay fever ☐Eczema ☐HIV

**Vascular:** ☐No problems ☐Leg pain while walking ☐Leg ulcers ☐Varicose veins ☐Blood clots ☐Swelling of the legs