Womack Army Medical Center, Fort Bragg, NC

Neurology 910-907-8460

New Patient Intake Form

Today's Date:_____

Name:_____

FMP/Sponsor's Last 4_____

Date of Birth_____

Welcome to our Neurology Clinic! The nervous system is very complex, and to serve you better its important that I learn more about your medical history, problems you have now and medical problems you've had in the past. Thank you very much for your patience in filling out this form before your appointment, even if this information is already in your chart.

Who referred you to a neurologist:

_____

Name of your primary care physician:

_____

Provider you are scheduled to see:

_____

Vital Signs:

Ht:_____ Wt:_____

B/P:_____ Pulse:_____

Temp:_____ Resp:_____

POX:_____

Drug/Food Allergies:_____

_____

Have you ever smoked or chewed tobacco

__No, I quite (date):_____

__Yes, How much per day:_____

How much alcohol do you drink per week:

_____

Have you ever used street drugs or drugs not prescribed to you:_____

_____

Any Sadness or Depression at this time:

Yes_____ No_____

If yes, Nursing is to complete PH2 and PHQ9 in TSWF. Alert provider of results

History of Current Problem:

1. Please describe in detail the problem or symptoms for which you're being seen today by the neurologist. (symptoms you're having, what body part it affects, how often it happens, how severe, etc.)

_____

_____

_____

2. When did this problem start (date):_____
3. Is there anything that triggered this problem:_____

_____

_____

_____

4. Does anything make this problem better or worse:_____

_____

_____

_____

5. Describe any of the following treatments you've tried and did they work:_____

_____

6. Self-care tried:_____
7. Medications:_____ *(Please Review and update 508 E)*
8. Physical Therapy: __Yes __No Date of Last Visit:_____
9. Surgery:_____

_____

_____

Other treatments (e.g. chiropractic or other):_____

10. What diagnostic tests have been done so far? (e.g. blood work, MRI, EMG, EEG, etc.)_____
11. Have you seen a Neurologist before for this problem? If so, what is the Neurologist's name/location?_____

_____

12. Date (s) you saw this doctor:_____

_____

Physician Notes:

Past Medical History. Please (CIRCLE) if you've ever had any of these Neurological or Muscle illnesses:

Headaches	Seizures	Concussion	Physician Notes:
Stroke TIA	Brain Aneurysm	Spells or loss of consciousness	
Carotid Stenosis Carotid or other Section	Bleeding in or Around the brain	Brain Radiation	
		Vision Loss	
Multiple Sclerosis Parkinson's Muscle diseases	Brain Surgery	Optic Neuritis	
	Brain Tumor	Sleep Disorders	
Genetic/Inherited Neurologic-Diseases	Meningitis	Problems with Walking	
	Multiple Sclerosis	Any other conditions not listed:	
Neuromas or Neurofibromas	Head Injury	_____	
		_____	
	Tremors	_____	
		_____	
	Neuropathy		

Neurology, WAMC/C. Phillips RN

REVIEW OF SYMPTOMS

GENERAL	Y	N	STOMACH	Y	N	NEUROLOGICAL	Y	N
Headache			Troubling swallowing			Stroke		
Lethargy/Weakness			Heartburn/indigestion			Seizures		
Chills/Night Sweats			Change in bowel habits			Head injury		
Fever			Loose stool/diarrhea			Memory loss		
Fainting			Black/bloody stools			Confusion		
Weight Loss			Frequent stomach pain			Trouble speaking		
Dizziness			Vomiting blood			Trouble swallowing		
EYES			Constipation			Unsteady gait		
Wears Glasses			Irritable bowel			Trouble walking		
Eyesight worsening			Ulcers			Arm/leg weakness		
Double vision			Stomach/bowel cancer			Arm/leg tingling		
Eye pain			KIDNEY PROSTATE			Arm/leg numbness		
EARS/NOSE/THROAT			Frequent voiding			PSYCHIATRIC		
Deafness			Burning urination			Nervous breakdown		
Noise in ears			Pus/blood in urine			Panic attacks		
Sore throat or tongue			Trouble starting			Cry often/depressed		
Congestion/sneezing			Dribble with			Worry a lot		
Sinus trouble/hay fever			Loss of urine control			Considered suicide		
Nose bleeds			Prostate disease/cancer			Loss of interest in eating		
Hoarse voice			Sexual difficulty			Anxiety/tension		
Dental problem			SKIN			Loss of energy/fatigue		
HEART			Rashes			ENDOCRINE		
Chest pain with exertion			Birthmarks			Unwanted weight		
Heart attack			Sores			Change in skin		
Heart Murmur			Dry/oily skin			Breast discharge		
Heart racing/palpitations			Hair growth/loss			Excessive thirst		
Irregular heartbeat			MUSCLE/BONES			Excessive tiredness		
Mitral valve prolapsed			Back pain			BREAST /MENSTRUAL		
High blood pressure			Neck pain			Endometriosis		
Swollen feet/ankles			Back surgery			Are you pregnant		
Heart valve replacement			Arthritis			Irregular menstrual period		
Atrial fibrillation			Fibromyalgia			Breast discharge		
LUNG			Aching muscles/joints			Lumps in breast		
Lung cancer			Shoe lift or braces			SLEEP		
Shortness of breath			Bone/joint injury			Dreams/sleep walk		
Chest pain			Osteoporosis			Legs twitch		
Coughing up phlegm			HEMATOLOGIC			Insomnia		
Cough up Blood			Blood disease			Daytime drowsiness		
Wheezing/cough			Enlarged glands			snores		
Pneumonia			Bleed/bruise easily			Breath holding/gasping		
			Anemia/low blood			Restless Sleep		

Please explain the CURRENT symptoms that you checked YES to on this page. Thank YOU.