SLEEP MEDICINE AND NEUROLOGY DR. SESI

New Patient Neurology Intake Form

First Name:	**Last Name:**
Date of Birth:	**Primary Care Provider:**
Appointment Date:	**Referring Provider:**

Have you had any of the following symptoms RECENTLY (over the past month)?

YES	NO		YES	NO		YES	NO	
		Headaches			Snoring			Weight Loss
		Eye Pain			Sleep trouble			Weight Gain
		Blurred Vision			Daytime Sleepiness			Frequent Fevers
		Double Vision			RLS			Sinus Congestion
		Hearing Loss			Tremor			Frequent Infections
		Ringing in the Ears			Anxiety or Depression			Arm Pain
		Dizziness/Lightheaded			Nausea			Arm Weakness
		Difficulty Swallowing			Stomach Pain			Arm Numbness
		Difficulty Speaking			Vomiting			Arm Tingling
		Facial Weakness			Diarrhea			Leg Pain
		Facial Numbness			Constipation			Leg Weakness
		Back or Neck Pain			Blood in Stool			Leg Numbness
		Tremor			Trouble Urinating			Leg Tingling
		Racing Heart Rate			Nocturnal Urination			Joint Pain
		Frequent Cough			Painful Urination			
		Shortness of Breath			Impotence			

Please provide details about any of the symptoms above that are currently bothering you: _____

_____

Are there any other symptoms that are bothering you that were not listed above?

_____

_____

Patient Signature: _____ **Date:** _____

Have you had any neurological studies performed (MRI, CT, EEG, EMG)?

If so, when? Where?

_____

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New Patient Intake Form Continued…

Have you had any of the following conditions?

YES	NO		YES	NO		YES	NO	
_____	_	Stroke/TIA	_____	_	Diabetes	_____	_	High Cholesterol
_____	_	Seizures	_____	_	Thyroid illness	_____	_	Sleep Apnea
_____	_	Heart Attack	_____	_	Kidney illness	_____	_	Abnormal Bleeding
_____	_	High Blood Pressure	_____	_	Liver illness	_____	_	Abnormal Clotting
_____	_	Pacemaker	_____	_	Cancer			

Other medical conditions *(please list):* _____

_____

Recent hospitalizations *(in past year) and major surgeries:* _____

_____

_____

Medication Allergies: _____

Family history of neurological or other disorders: _____

_____

Current Medication List	Strength (mg)	Directions

Social History:

YES	NO		
_____	_	**Do you smoke tobacco?**	_____ **= packs per day**
_____	_	**Do you drink alcohol?**	**Date quit:** _____
_____	_	**Are you married?**	_ **= drinks per week**
_____	_	**Do you have any children?**	_ **= total years married**
			_ **= total children**

_____ _____ **Are you currently employed? If so, what line of work?**