MANA Neurology
3344 N. Futrall Drive
Fayetteville, AR 72703
479-582-7330

General

Name ______________________________ DOB ______________ Age ________

Referring Physician ______________________________

What is the main problem? ______________________________

______________________________ Right Handed/Left Handed/Both

When did it begin? ______________________ What caused it? ______________________

What brings it on? ______________________________

What makes it better? ______________________________

What makes it worse? ______________________________

How long does it last? ______________________________

Past Medical History

List any health problems (diabetes, heart disease, high blood pressure, cancer, etc.)

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What hospitalizations have you had and when?

1. ______________________________ Date ______________
2. ______________________________ Date ______________
3. ______________________________ Date ______________
4. ______________________________ Date ______________
5. ______________________________ Date ______________

Medications

What medicines are you taking, BOTH prescription and non-prescription?

1. ______________ Dose ____________ Times per day ______________ How long ____________
2. ______________ Dose ____________ Times per day ______________ How long ____________
3. ______________ Dose ____________ Times per day ______________ How long ____________
4. ______________ Dose ____________ Times per day ______________ How long ____________
5. ______________ Dose ____________ Times per day ______________ How long ____________

Are you allergic to any medications? ______________________________

Have you suffered an accident ________________________________Date___________________MVA/Workers-Comp/Liability

Describe your accident ____

Your attorney's name ____Phone _____________________________

Are you in litigation or is it planned? ____

Personal and Family Information

Do you use tobacco _______________Type ____________________How much per day_____________How long_____________

Do you use alcohol _______________Type ____________________How much per day_____________How long_____________

Do you drink beverages with caffeine? _________________How much per day? _______________________________________

What is your most physically demanding activity that you do regularly? ____

____ How often? ____

What is your occupation? ____

How long? ____Your previous job __________________________________

Martial Status ____

Do you live alone ________ with a spouse ________ with parents ________ with children ________ with friends ________

Family History

Please record any health problems such as high blood pressure, heart disease, diabetes, headaches, seizures, stroke, memory loss, etc. If deceased, age at death and cause

Father ____

Mother ____

Brothers and Sisters ____

____

Children ____

Health Review *Please check any of these that you have recently had a problem with. If you do not check the symptom, then it is assumed it is not a problem for you.*

General

_______ Fever
_______ Weight Loss
_______ Night Sweats

Eyes

_______ Eye Pain
_______ Glaucoma
_______ Blurred vision not corrected by glasses
_______ Cataracts

Ears, Nose, Throat

_______ Trouble hearing
_______ Ringing of ears
_______ Trouble breathing through nose
_______ Difficulty swallowing
_______ Hoarseness

Cardiovascular

_______ Chest pain
_______ Rapid heart beat
_______ Irregular heart beat
_______ Rheumatic fever
_______ Blood clots in legs
_______ Phlebitis
_______ Shortness of breath lying down

Pulmonary

_______ Cough
_______ Coughing up phlegm
_______ Coughing up blood
_______ Pneumonia
_______ Collapsed lung
_______ Tuberculosis
_______ Shortness of breath when walking
_______ Asthma

Cardiovascular

_______ Snoring
_______ Quit breathing in sleep
_______ Daytime drowsiness
_______ Restless legs
_______ Excessive leg movement
_______ Insomnia

Gastrointestinal

_______ Indigestion
_______ Heart burn
_______ Nausea
_______ Vomiting
_______ Diarrhea
_______ Constipation
_______ Black stools
_______ Loss of appetite
_______ Ulcers
_______ Hiatal Hernia
_______ Jaundice
_______ Hepatitis
_______ Gall Stones
_______ Colitis of Enteritis
_______ Cirrhosis
_______ Pancreatitis
_______ Hemorrhoids

Genitourinary

_______ Urinary tract infections
_______ Burning with urination
_______ Dark or bloody urine
_______ Kidney stones
_______ Syphilis
_______ Gonorrhea
_______ HIV
_______ Other venereal diseases
_______ Trouble starting urination
_______ Bladder not emptying
_______ Decreased urinary stream

For Women

Date of last menstrual period ______________________________

Type of birth control practiced ______________________________

Are you pregnant? _______________

Pain or other problems with intercourse? ______________________________

Decreased sex drive? _____________

For Men

Difficulty with erection? ___________

Prostate? ________________________

Decreased sex drive? ____________

Discharge from penis? ____________

Neurological

_______ Headache
_______ Neck pain
_______ Back pain
_______ Weakness
_______ Numbness
_______ Unsteadiness
_______ Dizziness
_______ Loss of coordination
_______ Tremor, shaking
_______ Confusion
_______ Memory loss
_______ Spells, Seizures
_______ Stroke
_______ Traumatic brain injury

Musculoskeletal

_______ Joint stiffness, pain
_______ Joint swelling
_______ Muscle pain

Skin, Breast

_______ Rash
_______ Non-healing sores
_______ Changes in moles
_______ Breast pain or lump
_______ Breast discharge

Psychiatric

_______ Depression
_______ Anxiety
_______ Crying spells
_______ Hallucinations

Endocrine

_______ Change in menses
_______ Heat intolerance
_______ Cold intolerance
_______ Lactation

Hematologic/Lymphatic

_______ Anemia
_______ Fatigue
_______ Swollen Glands

Allergic/Immunologic

_______ Hayfever
_______ Frequent infections
_______ AID's

______________________________ Signature

______________________________ Date