Acct # _____ **OMAHA NEUROLOGICAL CLINIC, INC.**

Primary Care/Family Doctor: _____ Today's Date: _____

Name: _____ Age: _____ Date of Birth:_____

Race: _____ Occupation: _____

Reason for Referral:_____

Past Medical History: _____
_____

Past Surgical History: _____

Past Psychiatric History: _____

Past Traumas: _____

Medications/Dosages: _____
_____
(including over-the-counter medications, oral contraceptives, steroids, vitamins and supplements)

Medical Allergies: _____

Do you or have you used tobacco? ____ How long? _____ Type and amount: _____
Do you use alcohol? _____ Type and amount: _____
Do you use illicit (street) drugs? _____ Type and amount: _____
(Optional) Physical, sexual or emotional abuse history? _____
Are you disabled? If so, how long and for what reason. _____
Do you have legal counsel? _____
Colorectal screening (ages 50 thru 75) _____ Performed _____ Not Performed
Flu vaccine _____ Performed _____ Not Performed Date done: _____
Pneumonia vaccine _____ Performed _____ Not Performed Date done: _____

Family History

Father - Living or Deceased , age ____, health status _____
Mother- Living or Deceased, age ____, health status _____
Brothers, how many ____ Living ____ Deceased, health status _____
Sisters, how many ____ Living ____ Deceased, health status _____
Children, how many ____ Living ____ Deceased, health status _____
Any hereditary diseases in the family? _____
_____

1.	Do you have fevers?	Yes _____	No _____
2.	Do you have chills?	Yes _____	No _____
3.	Do you have night sweats?	Yes _____	No _____
4.	Is your appetite bad?	Yes _____	No _____
5.	Is your weight up?	Yes _____	No _____
6.	Is your weight down?	Yes _____	No _____
7.	Do you have chest pains?	Yes _____	No _____
8.	Do you have palpitations?	Yes _____	No _____

(PLEASE CONTINUE ON NEXT PAGE)

9.	Do you have shortness of breath?	Yes _____	No _____
10.	Do you have a cough?	Yes _____	No _____
11.	Do you have sputum production?	Yes _____	No _____
12.	Do you have nausea?	Yes _____	No _____
13.	Have you been vomiting?	Yes _____	No _____
14.	Do you have heartburn?	Yes _____	No _____
15.	Do you have diarrhea?	Yes _____	No _____
16.	Do you have constipation?	Yes _____	No _____
17.	Do you have blood in the urine?	Yes _____	No _____
18.	Do you have blood in the stool?	Yes _____	No _____
19.	Do you have loss of smell?	Yes _____	No _____
20.	Do you have loss of vision?	Yes _____	No _____
21.	Do you have double vision?	Yes _____	No _____
22.	Do you have pain in the eyes?	Yes _____	No _____
23.	Do you have hearing loss, wear hearing aids?	Yes _____	No _____
24.	Do you have ringing in the ears?	Yes _____	No _____
25.	Are you experiencing dizziness?	Yes _____	No _____
26.	Are you experiencing spinning?	Yes _____	No _____
27.	Are you experiencing swaying?	Yes _____	No _____
28.	Are you lightheaded?	Yes _____	No _____
29.	Have you been choking?	Yes _____	No _____
30.	Have you been gagging?	Yes _____	No _____
31.	Are you having difficulty swallowing?	Yes _____	No _____
32.	Is your speech strained?	Yes _____	No _____
33.	Is your speech slurred?	Yes _____	No _____
34.	Is your speech hoarse?	Yes _____	No _____
35.	Do you have headaches?	Yes _____	No _____
36.	Do you have sinus congestion?	Yes _____	No _____
37.	Do you have sinus drainage?	Yes _____	No _____
38.	Are you having sleeping problems?	Yes _____	No _____
39.	Do you have neck pain?	Yes _____	No _____
40.	Do you have thoracic back pain?	Yes _____	No _____
41.	Do you have low back pain?	Yes _____	No _____
42.	Do you have numbness of your face?	Yes _____	No _____
43.	Do you have numbness in your arms?	Yes _____	No _____
44.	Do you have numbness in your legs?	Yes _____	No _____
45.	Do you have weakness of your face?	Yes _____	No _____
46.	Do you have weakness in your arms?	Yes _____	No _____
47.	Do you have weakness in your legs?	Yes _____	No _____
48.	Do you have trouble controlling your bladder?	Yes _____	No _____
49.	Do you have trouble controlling your bowels?	Yes _____	No _____
50.	Have you ever fainted or blacked out?	Yes _____	No _____
51.	Have you ever had a convulsion/seizure?	Yes _____	No _____
52.	Have you ever been paralyzed?	Yes _____	No _____
53.	Did you have any problems at birth?	Yes _____	No _____
54.	Do have difficulty with anxiety/nervousness?	Yes _____	No _____
55.	Do you feel discouraged or depressed?	Yes _____	No _____
56.	Are you having difficulty with your sex life?	Yes _____	No _____
57.	Have you ever been anemic or had transfusions?	Yes _____	No _____