220 EXECUTIVE CENTER PARKWAY
FREDERICKSBURG, VA 22401
(540) 899-2900 • FAX (540) 372-6928

NEUROLOGY ASSOCIATES of Fredericksburg

NAME:_____ AGE:_____ REFERRING DOCTOR:_____
DATE:_____ RIGHT-HANDED OR LEFT-HANDED: _____
REASON FOR NEUROLOGICAL CONSULTATION:_____

NO.	PAST HISTORY	YES	NO	
1.	DIABETES			**Drug Allergies:** _____
2.	HYPERTENSION			_____
3.	HIGH CHOLESTEROL			
4.	CANCER			
5.	STROKE			
6.	HEART TROUBLE/HEART ATTACK			
7.	THYROID PROBLEMS			
8.	ARTHRITIS/GOUT			
9.	CONVULSIONS/EPILEPSY			
10.	BLEEDING TENDENCY			
11.	ACUTE INFECTIONS			
12.	VENEREAL DISEASE			
13.	HEREDITARY DEFECTS			
14.	ALLERGIES			
15.	PSYCHIATRIC PROBLEMS			
16.	GI/LIVER DISEASE			
17.	PULMONARY DISEASE/PNEUMONIA			
18.	HIV TESTING			**RESULT:**

FAMILY HISTORY -- CHECK IF YES -- EXPLAIN ABOVE

☐ heart disease ☐ neuropathy/numbness ☐ Alzheimer's disease/dementia FATHER (AGE/HEALTH) _____
☐ gait disorder ☐ seizure/epilepsy ☐ tremor/Parkinson's disease MOTHER (AGE/HEALTH)_____
☐ stroke ☐ multiple sclerosis ☐ muscle disease/weakness SIBLINGS (AGE/HEALTH) _____
☐ headaches ☐ hereditary illness ☐ other medical illnesses _____

NEUROLOGICAL TESTING	YES	NO	DATE	RESULT
MRI SCAN				
CT SCAN				
X-RAYS				
ARTERIOGRAM/CAROTID ULTRASOUND				
EVOKED POTENTIAL STUDIES				
EMG				
ELECTROENCEPHALOGRAM				

SOCIAL HISTORY

Occupation:_____ **Tobacco:** (amount) _____ **Alcohol:** (amount) _____
Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Children _____
Exposure to: Fumes ☐ Dust ☐ Solvents ☐ Air-Borne Particles ☐

CHRONIC ILLNESSES STATUS	PRIOR HOSPITALIZATIONS/SURGERIES/INJURIES DATE
1.	
2.	
3.	
4.	

MEDICATION:

1. 4. 7.
2. 5. 8.
3. 6. 9.

_____ _____ _____
Patient Signature Date MD Signature

PLEASE ALSO COMPLETE REVIEW OF SYSTEMS ON REVERSE SIDE