

South Atlanta Neurology & Pain Clinic, P.C.

Initial Clinical Data Form (rev 7-05)

Please fill out the following questionnaire as best as you can. This will help us to evaluate your medical condition more effectively and thoroughly. Your cooperation will be greatly appreciated.

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Referral Physician/Source (Who sent you to this clinic? ): Dr \_\_\_\_\_

Primary Care Physician: Dr. \_\_\_\_\_

AGE: \_\_\_\_\_ Which hand is dominant? Right / Left / Equal

RACE: White / African American / Asian / Hispanic / Other GENDER: Male / Female

\*Please list your **MAIN SYMPTOMS** that concern you. List the most bothersome symptoms first: (Location, Severity, Timing, Duration, Quality, Modifying factors, Assoc sx) >4

1. \_\_\_\_\_

\_\_\_\_\_

2. \_\_\_\_\_

\_\_\_\_\_

3. \_\_\_\_\_

\_\_\_\_\_

4. \_\_\_\_\_

\_\_\_\_\_

5. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\*If you have any of following **symptoms** which were not mentioned above, please circle them:

Fever, Wt loss, Wt gain, Fatigue, Daytime Drowsiness, Sleep disturbance, Memory loss, Sad feeling, Hallucination,

Blurry vision, Double vision, Swallowing difficulties, Slurry speech, Headache, Dizziness,

Hearing loss, Ringing in the ear, Sinus/nasal congestion,

Shortness of Breath, Chest Pain, Abdominal pain, Nausea/Vomiting, Diarrhea, Urinary incontinence, Stool incontinence, Changes in Menstrual Cycle,

Weakness, Numbness, Neck pain, Low Back Pain, Arm Pain, Leg pain

\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY:**

\*If you have or have had any of following medical conditions, please circle them and write the year that the diagnosis was given:

<u>Stroke</u>	<u>Seizure</u>	<u>Depression</u>	<u>Sleep disorder</u>
<u>Head trauma</u>	<u>Heart Attack</u>	<u>Heart disease</u>	<u>Hypertension</u>
<u>High Cholesterol</u>	<u>Diabetes</u>	<u>Thyroid disease</u>	<u>Spine disorder</u>
<u>Blood vessel disorder</u>	<u>Blood disorder</u>	<u>Bone disease</u>	<u>Arthritis</u>
<u>Lung disorder</u>	<u>Asthma/Emphysema</u>	<u>Sinusitis</u>	<u>Skin disease</u>
<u>Kidney disease</u>	<u>Liver disorder</u>	<u>Stomach/GI disease</u>	<u>Autoimmune disorder</u>
<u>Cancer</u>			

ANY OTHER medical conditions?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List of previous **SURGERY** in your life:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List of current **MEDICATIONS**:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Are you **ALLERGIC** to any medication?: \_\_\_\_\_

**SOCIAL HISTORY:** Occupation; \_\_\_\_\_ Marital Status; \_\_\_\_\_

Who do you live with ? \_\_\_\_\_ City; \_\_\_\_\_

Alcohol; \_\_\_\_\_ per week for \_\_\_\_\_ yrs. Tobacco Use; \_\_\_\_\_ pack a day for \_\_\_\_\_ yrs.

Illicit Drug Use; \_\_\_\_\_

**FAMILY HISTORY:** Does any of following medical diseases affect any of your relatives including parents, grand parents, siblings, and children? (Do not include spouse)

<u>Stroke</u>	<u>Seizure</u>	<u>Depression</u>	<u>Sleep disorder</u>
<u>Head trauma</u>	<u>Heart Attack</u>	<u>Heart disease</u>	<u>Hypertension</u>
<u>High Cholesterol</u>	<u>Diabetes</u>	<u>Thyroid disease</u>	<u>Spine disorder</u>
<u>Blood vessel disorder</u>	<u>Blood disorder</u>	<u>Bone disease</u>	<u>Arthritis</u>
<u>Lung disorder</u>	<u>Asthma/Emphysema</u>	<u>Sinusitis</u>	<u>Skin disease</u>
<u>Kidney disease</u>	<u>Liver disorder</u>	<u>Stomach/GI disease</u>	<u>Autoimmune disorder</u>
<u>Cancer</u>			

Any HEREDITARY disorders (including Neurological and Non-neurological)