ABINGTON NEUROLOGICAL ASSOCIATES, Ltd.

Dear_____**You have an appointment with Dr.**_____

on_____**at**_____**at our office at:**

❑ **1245 Highland Ave., (Price Medical Office Bldg.), St. 301 Abington, PA 19001** **215-957-9250**

❑ **2325 Maryland Road, Suite 120 Willow Grove, PA 19090** **215-957-9250**

The following information is very important to your health. Please take the time to fully and accurately fill out this form. While we take a detailed medical history during your examination, this information is helpful to record prior to the appointment. Please obtain MRI and CT scan results, and laboratory studies prior to your appointment. Please note that we require 24 hours notice for any cancellation. When we give patients an appointment, we are scheduling an hour specifically to be spent with you. Missing an appointment or not notifying us of cancellation means that we cannot offer your time to another patient who may seriously need it. Therefore, failure to notify us will result in a $50 charge. Co-payments are due at the time of the visit.

Name:_____Birthdate:_____Age:_____

Marital Status (circle): M / S / W / D Children #:_____ Occupation:_____

Height:_____ Weight:_____ Handedness (circle one): Right Left Ambidextrous

Please list the names of the physicians you see on a regular basis: **Copies of our consultation/office note will be sent to those physicians listed below unless we are requested not to do so.**

Primary or family physician:_____Other:_____

Chief Complaint(s) / Symptom(s) (e.g. headache, dizziness, left leg weakness, memory loss, etc.)?_____How long have you experienced the problem?_____

Have you had any tests or speciality evaluation for the problem? Include place, date, body part if known.

MRI Scan:_____

CAT Scan_____

Vascular Studies_____

Blood Tests:_____

Specialists:_____

Other_____

for office use_____

REVIEW OF SYSTEMS NEUROLOGICAL: Please check if you have had problems with any of the following:

❑ Headache_____	❑ Pain/Stiffness_____
❑ Weakness_____	❑ Handwriting Problems_____
❑ Numbness_____	❑ Clumsiness_____
❑ Dizziness/Vertigo_____	❑ Tremor_____
❑ Loss of Balance_____	❑ Muscle Twitching_____
❑ Double Vision_____	❑ Involuntary movements_____
❑ Loss of Vision_____	❑ Hallucinations_____
❑ Ringing in the ears_____	❑ Loss of consciousness_____
❑ Hearing Loss_____	❑ Personality change_____
❑ Speech difficulty_____	❑ Stroke/TIA_____
❑ Swallowing difficulty_____	❑ Seizures_____
❑ Hoarseness_____	❑ Memory Loss_____

REVIEW OF SYSTEMS MEDICAL:

- ❑ Chest pain/Angina_____
- ❑ Palpitations_____
- ❑ Fainting_____
- ❑ Shortness of breath_____
- ❑ Swelling of legs_____
- ❑ Wheezing/ ❑ Cough_____
- ❑ Sore Throat_____
- ❑ Abdominal pain/Colitis_____
- ❑ Diarrhea/ ❑ Constipation _____
- ❑ Nausea/vomiting_____
- ❑ Blood in stool_____
- ❑ Joint pain_____
- ❑ Muscle pain_____
- ❑ Urinary frequency/urgency_____
- ❑ Blood in urine_____
- ❑ Urinary incontinence_____
- ❑ Sexual dysfunction_____
- ❑ Menstrual dysfunction_____
- ❑ Fever/Chills_____
- ❑ Sweating_____
- ❑ Rash or lump_____
- ❑ Change in hair/nails_____
- ❑ Weight loss/ ❑ Weight gain_____
- ❑ Loss of appetite_____
- ❑ Excessive thirst_____
- ❑ Other_____

PAST MEDICAL HISTORY

Have you ever had: When and how long?

- ❑ High blood pressure_____
- ❑ Diabetes_____
- ❑ Thyroid Disease_____
- ❑ Heart failure/CHF_____
- ❑ Heart Attack/MI_____
- ❑ Emphysema/COPD_____
- ❑ Pneumonia/ ❑ TB_____
- ❑ Anemia_____
- ❑ Bleeding _____
- ❑ Ulcers_____
- ❑ Arthritis_____
- ❑ HIV/AIDS_____
- ❑ Lupus_____

Other illnessess: year of onset name of illness

Previous injuries: year of injury type of injury

Hospital admissions or surgeries: year, place, reason for admission/surgery

MEDICATIONS (Include drops, sprays, birth control pills, over-the-counter meds, pain pills, etc.)

Name of Drug	Size (Mg.)	# per day	How long Taken	When Stopped

Are you **allergic** to (please circle): drugs or medications x-ray dye other substances

*If yes, please specify:*_____

HABITS

Do you smoke cigarettes **now**? **Yes** **No** Did you **previously** smoke cigarettes? **Yes** **No**

If yes, how many packs per day?_____packs. For how many years did you smoke?_____years.

How long ago did you quit?_____months_____years Why?_____

Do you use other forms of tobacco? **Yes** **No** **If yes**, what types?_____

How many **alcoholic drinks** do you have **on average** during a usual 24-hour period?

	weekday	weekend
bottles (cans) of beer?	_____	_____
glasses of wine?	_____	_____
shots or ounces of liquor?	_____	_____

Do you consume significantly **less alcohol now** than in the past (circle) **Yes** **No**

How much of these fluids do you drink in a 24-hr period?

coffee **(with caffeine)**?_____cups tea?_____cups cola drinks **(with caffeine)**?_____cans

SLEEP/EMOTIONAL HISTORY (Please circle Yes or No)

Do you sleep well? **Y N** Do you have trouble falling asleep? **Y N** Staying asleep **Y N**

Do you snore? **Y N** Do you stop breathing in your sleep? **Y N** Do you have restless legs **Y N**

Leg jerks while sleeping? **Y N** Are you excessively sleepy during the day? **Y N**

Do you suffer from depression? **Y N** Anxiety? **Y N** Other?_____

Have you sought psychological or psychiatric treatment? **Y N**

FAMILY HISTORY

Identify each family member by placing their **present age or age at death** in the appropriate block. Include only blood realtives. **If deceased,** write the letter **"D"** next to the age.

Mother [ ] Father [ ]

Sisters [ ] [ ] [ ] [ ] Brothers [ ] [ ] [ ] [ ]

Daughters [ ] [ ] [ ] [ ] Sons [ ] [ ] [ ] [ ]

Please check:	**Mother**	**Father**	**Sister**	**Brother**	**Daughter**	**Son**	**Other**
Headaches	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Epilepsy or Seizures	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Multiple Sclerosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Parkinson's Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Alzheimer's Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Brain Tumor	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Other Neurological	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Hypertension	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Thyroid	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Lung Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney Disease	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]
Psychiatric problems	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]

List any other diseases which are common among your relatives:_____

_____

_____

Additional Information or Comments:

_____

_____

_____

_____

_____

_____

The above information is true and correct to the best of my belief.

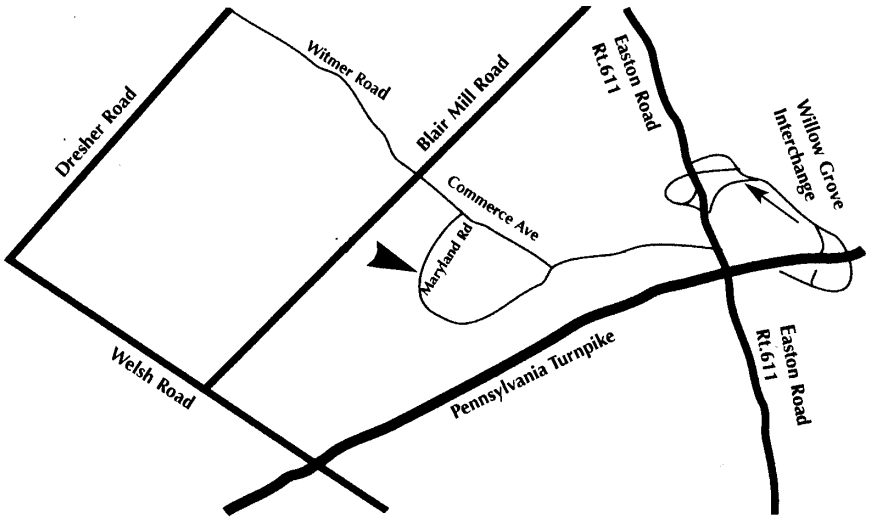
Signed:_____ **Date:**_____

If form is completed and/or signed by person other than the patient, please specify relationship (e.g. spouse, cousin, friend, etc.):_____

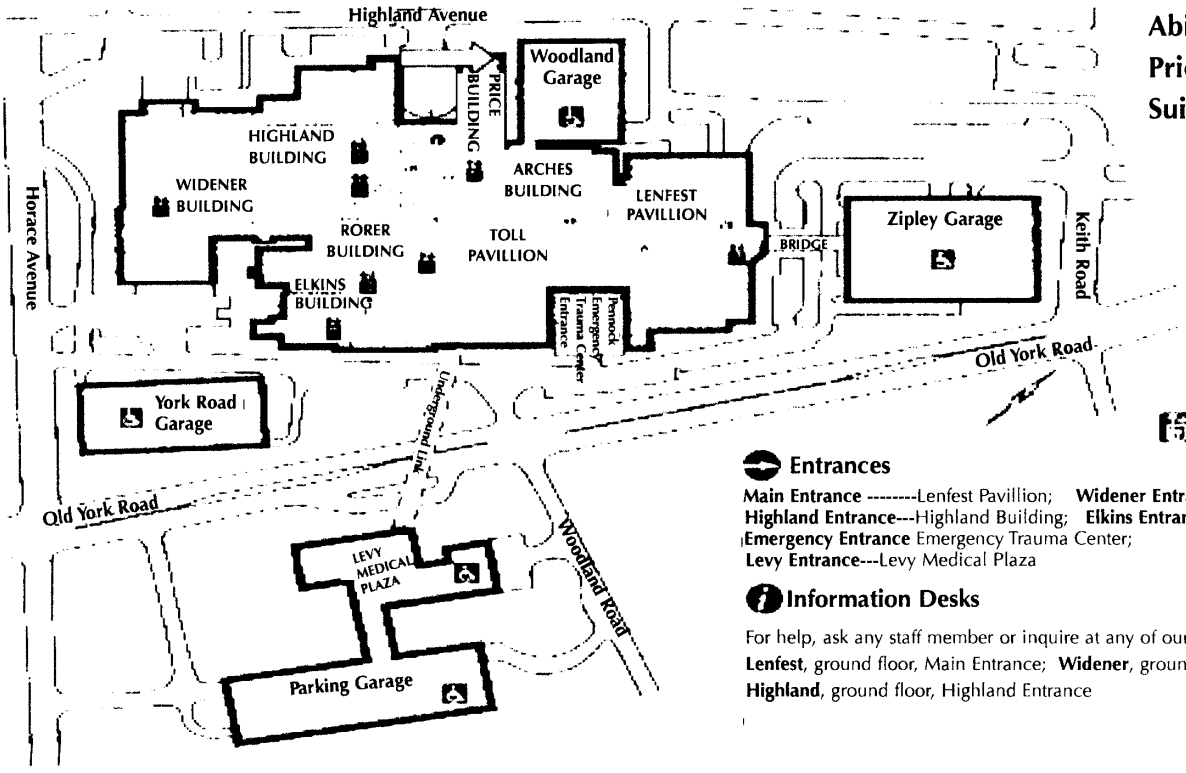
_____

_____

Office use: Reviewed_____ **Date**_____



Willow Grove Office
2325 Maryland Road
Suite 120



Abington Office
Price Building (MOB)
Suite 301

Elevators

Entrances

Main Entrance --------Lenfest Pavillion; **Widener Entrance**--- Widener Building;
Highland Entrance---Highland Building; **Elkins Entrance**---Elkins/Rorer Building;
Emergency Entrance Emergency Trauma Center;
Levy Entrance---Levy Medical Plaza

Information Desks

For help, ask any staff member or inquire at any of our information desks.
Lenfest, ground floor, Main Entrance; **Widener**, ground floor, Widener Entrance
Highland, ground floor, Highland Entrance