Atrium Health

Neuroscience Institute Neurology – Pineville New Patient Registration Form

Patient Name : _____ DOB : _____

(1) FAMILY HISTORY: Please circle all of the following that any of your blood relatives have:

Aneurysm	Brain Tumor	Headaches	Psychiatric Disorders
Asthma	Cancer, Type: _____	High blood pressure	Stroke
Alzheimer's disease	Diabetes	Migraines	Thyroid Disease
Arthritis	Depression/Anxiety	Multiple Sclerosis	Tremor
Autoimmune disease	Epilepsy/Seizures	Parkinson's Disease	Others, Please Specify:
Bleeding / Clotting Problems	Heart Disease	Peripheral neuropathy	

(2) PLEASE LIST ANY ALLERGIES TO MEDICATIONS

_____

_____

SOCIAL HISTORY

Tobacco Use: Yes / No If Yes, ___ packs per day. If No, ☐ Never ☐ Stopped after _____ years since _____

Alcohol: Yes / No If Yes, __ drinks per day / week. If No, ☐ Never ☐ Stopped after _____ years since _____

Have you ever had difficulty with substance abuse? Yes / No

Please describe the substance, when and for how long? _____

Caffeinated beverages: Yes / No If yes, _____ drinks per day.

Whom do you live with: ☐ Spouse ☐ Children ☐ Other _____

Occupation, Current or when working full time: _____

Over →

REVIEW OF SYSTEMS: Please circle all the conditions applicable to you:

GENERAL	EYES	GENITO-URINARY	NEUROLOGIC
Weight gain: _____ Weight loss: _____	Blurred vision Double Vision	Incontinence Urgency	Dizziness on standing up, or on turning in bed
Fatigue	Sudden blindness for a few minutes	Frequent urination	Loss of consciousness
Fever / Chills	Eye pain	Nighttime urination	Vertigo
Sweats	Droopy eyelids	Sexual dysfunction	Numbness / Tingling
Intolerance: Heat / Cold	Flashing lights	Other:_____	Burning sensations
Other: _____	Blind spots		Weakness / Paralysis
			Seizures
CARDIOVASCULAR	**EAR, NOSE, THROAT**	**SKIN**	Imbalance / Falls
Chest pain	Ringing in ears	Rash / Itching / Hives	Speech disturbance
Palpitations	Loss of hearing	Hair loss	Headaches
Heart murmur	Earache	Other	Facial drooping
Poor circulation	Nose Bleeds		Tremor
Swelling of Ankles	Loss of smell		Other: _____
	Loss of taste		
RESPIRATORY	Hoarseness	**MUSCLES, JOINTS, BONES**	**MEMORY**
Wheezing	Sinus infections	Morning stiffness	Normal
Chronic cough	Difficulty swallowing: Solid / Liquid	Neck pain/ Back pain Joint Pain	Forgetful
Shortness of breath		Muscle cramps / Spasm	Can't balance checkbook
	GASTROINTESTINAL	Muscle weakness	Need help bathing, dressing, feeding
SLEEP	Poor appetite	Difficulty Walking	Get lost driving
Snoring	Nausea / vomiting	Difficulty with: - Getting up from chair - Lifting arms above shoulders - Climbing stairs - Other, Specify:	Wandering
Stop breathing in sleep	Diarrhea		
Day time sleepiness	Indigestion / Heartburn		**PSYCHIATRIC**
Not refreshed	Constipation		Depression
Headache on waking up	Abdominal Pain		Panic Attacks
Excessive sweating	Liver disease		Anxiety
Tossing & Turning			Hallucinations
		Osteoporosis	

I have read and received a copy of the NIN Policy form. I have read the NIN Privacy policy and understand that I can request a copy. I therefore understand my rights and obligations with reference to Neuroscience Institute Neurology (NIN), agree to abide by NIN terms and conditions and give NIN necessary authorizations, consents, waivers and assignments by way of my signature below.

_____

Signature Print Name Date