Athens Neurological Associates History and Physical

Patient Information
Chart Number: ______________________________________ Date: ____________ Preferred Pharmacy: ____________________

Full Name: ____ Age : ____________

Right-handed Left-handed (please circle one)

Referred by: ____
Primary Care Provider : ______________________________

Chief Complaint: What is your main problem?

History of Present Illness:
What/where is the problem? Please describe:

How long have you had the problem?
When do symptoms occur?
How often do symptoms occur and how long do they last?
What makes the problem better/improves symptoms?
What makes the problem worse?
How severe is the problem?
How many days of school/work have you missed due to this?
Other:

Tests: What lab tests, x-rays, etc. have you had done related to your main problem?

Past Medical History (if extra space needed, please request an additional page)
Medical Problems: please list all of your other medical problems an when you were diagnosed
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Previous hospitalizations/surgeries:
Reason: Date: Location:
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

GYN:

Last menstrual period: Date of menopause:
Number of pregnancies: Number of miscarriages:
Number of births: Last PAP smear and mammogram and results:

Medications: including all prescriptions/vitamins/birth control/hormones/over-the-counter medications, their dosage, and how many times you take them per day
1.
2.
3.
4.
5.
6.
7.
8.
9.

Drug allergies: list allergies and you type of reaction to it
1.
2.
3.

Family History:

Mother: Living /Deceased Age of death Medical problems

Father: Living /Deceased Age of death Medical problems

Siblings (list): Living /Deceased Age of death Medical problems

Children (list): Living /Deceased Age of death: Medical problems

Please list any other medical conditions that run in your family:

Social History (Adult Patients Only – Pediatric Patients go to next page):

Occupation: Highest level of education:
Please circle one: Married Single Divorced
Widowed Separated Other:
Important activities/hobbies:
Do you smoke/did you ever smoke? If yes, how many packs per day?
Did you quit smoking? When?
Do you drink alcohol? If yes, what and how much?
Do you drink caffeine? If yes, what and how much?
Other drug use:
Is there a lawsuit regarding your current problem or is the problem possibly related to a car accident?

Child Development (Pediatric Patients Only – Adult Patients go to last question on page):

Please indicate the approximate age your child performed each of the following: . All Normal

Smiled _____________ Rolled over _______ Sat up without help _________ Walked ___________Walked up stairs ________

Spoke first words __________ Spoke words besides Mama or Dada _________ Was potty trained ___________

Has the child ever . . .

Had a seizure?	Yes	No
Suffered a head trauma?	Yes	No
Had Meningitis or encephalitis?	Yes	No
Used alcohol or drugs?	Yes	No
Been physically, sexually or emotionally abused?	Yes	No

Birth History ***(Pediatric Patients Only):***

Birth weight __________________

Problems with pregnancy: Infection Fever High blood pressure
Diabetes Smoked Drank alcohol Used street drugs

Delivery: vaginal Cesarean (C-Section)

Problems with delivery? No Yes ____

Birth was: Full term Late Early Week gestation _____________________________

Social History ***(Pediatric Patients Only- Adult Patients go to last question on page):***

Current grade placement ________ Grades repeated _____________ Name of School _____________________________

Does patient receive physical therapy? No Yes Occupational therapy? No Yes

Speech therapy? No Yes

Mother: Age____________ Occupation ____ Married/Single/Divorced/Separated

Father: Age____________ Occupation ____ Married/Single/Divorced/Separated

Please tell us anything else about *yourself or your condition* that we may need to know:

All Patients - System Review

(Please indicate any conditions you have experienced in the past month ***NOT*** already detailed above)

Constitutional	**Ears, Nose, Mouth, Throat**	**Cardiovascular**	**Gastrointestinal**
Altered taste/smell	Balance problems	Angina	Abdominal pain
Change in appetite	Allergies/Hay Fever	Chest pain	Indigestion
Weight loss	Ringing in ears/tinnitus	Chest pressure	Diarrhea
Weight gain	Hearing loss	Fainting	Gastritis
Unable to sleep	Trouble breathing through nose	Heart failure	Hepatitis
Excessive sleepiness	Sinus disease	High blood pressure	Hiatal Hernia
Fatigue	Mouth sores	Low blood pressure	Rectal bleeding
Unexplained fever	Sore throat	Shortness of breath	Ulcer
Abnormal growth	Trouble swallowing	Leg swelling	Vomiting
Lost interest in Activities	Snoring	Coronary disease	Reflux
Birthmark			

Heme-Lymphatic	**Psychiatric**	**Respiratory**	**Eyes**
Blood disorder	Anxiety	Bronchitis	Blurred vision
Diabetes	Depression	Emphysema	Double vision
Sickle Cell disease	Trouble concentrating	Pneumonia	Glaucoma
Thyroid disease	Hallucinations (seeing/hearing things)	Tuberculosis	Cataracts
Enlarged lymph nodes	Schizophrenia	Chronic cough	Loss of peripheral vision
HIV	In trouble at school	Asthma	"Floaters"
AIDS	Shy		Macular Degeneration

Musculoskeletal	**Genitourinary**	**Integumentary**	**Endocrine**
Low back pain	Urine incontinence	Breast disease	Allergic/Immunologic
Neck pain	Stool incontinence	Skin rash/eczema	
Joint pain	Sexual dysfunction	Melanoma	
Joint swelling	Constipation	Basal Cell Cancer	

Neurological Complaints

Dizziness	Facial numbness/tingling	Choking	Difficulty sleeping

Hallucination	Numbness-Arms	Numbness-Legs	Swallowing problems
Headache	Nausea	Difficulty tasting	Trouble with smell
Memory problems	Poor coordination	Drooling	Seizures/convulsions
Personality change	Speech difficulty	Trouble walking	Head trauma
Weakness (where?)	Stiffness	Vertigo	Spells/Fits
Pain	Difficulty chewing	Difficulty concentrating	Confusion
Aggressive	Clumsy or poor coordination	Fainting or passing out	Hostile/Angry
Speech problems	Stares off into space	Tremor	Trouble hearing
Trouble learning			

Physician or Nurse Practitioner signature: ___________________________________ Date: _________________

Physical Exam Notes (MD or NP to complete)

Vital Signs T_______ BP ________ P________ R_______ Wt _________ Ht _________

General Exam Notes:

Neurological Examination Notes:

Mental Status (A&O, language, knowledge, concentration, MMSE etc):

Cranial Nerves:

Fundus:

CV (auscultation, carotids, peripheral pulses):

Pulm:

Motor (strength, tone, ROM):

Sensory:

Coord/Cerebellar:

Gait:

DTR's:

Counseling/Coordination of Care Time – with ≥ 50% FTF time* (circle if applicable)

40minutes (level 3) **60 minutes** (level 4) **80 minutes** (level 5)

**Face to face time spent discussing issues with the patient and/or family as described above*

Assessment

1.

2.

3.

4.

Plan

1.

2.

3.

4.

Signature: ____ Date: _______________________________