Dr. Shaik Ubaid

Neurologist

101 Jordan Road
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New Patient Health History

Date of Visit: _____ Patient Name: _____

DOB: _____ Age: _____ Height: _____ Weight:_____ Hand Dominance: ___L ___R

Primary Care Provider:_____

Other Providers: _____

What is your major neurological complaint or why did you ask your doctor to see a neurologist?

_____

_____

_____

_____

Current Medications:

Medication Name	Dosage	Frequency

Date of visit:_____ Patient Name: _____ **DOB:** _____

Name and address of current pharmacy:_____

Medication Allergies:

WHAT MEDICATIONS HAVE YOU TRIED IN THE PAST FOR THIS PROBLEM?

Medication name	Strength	Reason for stopping

Surgical History:

Surgery Type	Doctor/Facility	Date

Social History :

Do you smoke Tobacco?_____**Yes(** _____**/Day, Type:** _____**) Quit** _____**(How long ago?**_____**)** _____ **Never**

Do you drink alcohol? __ Yes (How much/Often_____**)** _____**Never**

Do you use Marijuana or any illicit drugs ____ **Yes** ___ **No If yes Please Explain:** _____

What is your occupation? _____ **Marital Status:** _____ **How many children?** _____

Do you drink caffeine? ____ **Yes (How much/often** _____ **) No**_____

What is your occupation? _____ **Marital Status:** _____ **How many children?** _____

PAST MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

ARTHRITIS RHEUMATOID/SARCOID/ PSORIASIS _____YES _____NO	HEADACHE OR MIGRAINE ____ YES _____ NO	STROKE _____ YES _____ NO
CANCER TYPE: _____ _____ YES _____NO	HIGH BLOOD PRESSURE ____ YES ____ NO	THYROID CONDITION _____ YES ___ NO
DEMENTIA: _____ YES _____NO	HIGH CHOLESTREOL ____ YES ____ NO	MULITPLE SCLEROSIS ____ YES _____ NO
DIABETES: ____ YES ____ NO	NEUROPATHY _____ YES ___NO	ULECERATIVE COLITIS/ CROHN'S DISEASE _____ YES _____ NO
EPILEPSY: _____ YES ____ NO	PARKINSONS DISEASE ____ YES _____ NO	OTHER SIGNIFICANT/PAST HISTORY:

FAMILY MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

ARTHRITIS RHEUMATOID/SARCOID/ PSORIASIS _____ MOTHER _____ FATHER _____ SIBLING	HEADACHE OR MIGRAINE _____MOTHER _____ FATHER _____ SIBLING	STROKE _____MOTHER _____ FATHER _____ SIBLING
CANCER TYPE: _____ _____ MOTHER ____ FATHER _____ SIBLING	HIGH BLOOD PRESSURE _____MOTHER _____ FATHER _____ SIBLING	THYROID CONDITION _____MOTHER _____ FATHER _____ SIBLING
DEMENTIA _____MOTHER _____ FATHER _____ SIBLING	HIGH CHOLESTREOL _____MOTHER _____ FATHER _____ SIBLING	MULITPLE SCLEROSIS _____MOTHER _____ FATHER _____ SIBLING
DIABETES ____MOTHER _____ FATHER _____ SIBLING	NEUROPATHY _____MOTHER _____ FATHER _____ SIBLING	ULCECERATIVE COLITIS/ CROHN'S DISEASE _____MOTHER _____ FATHER _____ SIBLING
EPILEPSY: _____MOTHER _____FATHER SIBLING _____	PARKINSONS DISEASE ____ MOTHER _____ FATHER _____ SIBLING	OTHER SIGNIFICANT/FAMILY HISTORY:

Patient Name: _____ **Date** _____

REVIEW OF SYSTEMS

PLEASE CIRCLE ALL THAT APPLY

CONSTITUTIONAL -Fever -Night sweats -Lack of energy -Weight gain(___lbs.) -Weight loss(___lbs.)	GASTROINTESTINAL -Abdominal pain -Vomiting -vomiting blood -Nausea -Diarrhea -Constipation -Bowel loss of control	INTEGUMENTARY -Rash -Itching -Dry skin -Growths/Lesions
EYES -Dry eyes -Irritation -Vision changes -Ptosis(drooping) -Abnormal eye	GENITOURINARY -Urinary loss of control -Difficulty urinating -Increased urination -Hematuria (blood in urine) -Nocturia (excessive night time urination)	PSYCHIATRIC -Depression -Sleep disturbances -Restless legs -Anxiety -Hallucinations
E.N.M.T -Hearing loss -Ear pain -Sinus problems -Sore Throat -loss of smell -Facial swelling -Mouth ulcers -Trouble swallowing	MUSCULOSKELETAL -Muscle aches -Neck pain -Muscle weakness -Back pain -Joint pain -Difficulty breathing	ENDOCRINE -Fatigue -Cold intolerance -Increased thirst -Hair loss -Heat intolerance
CARDIOVASCULAR -Angina (chest pain) -Swelling of extremities -Palpitations -Known heart murmur -Lightheadedness upon standing	NEUROLOGIC -Fainting -Weakness -Migraines -Numbness/tingling -Headaches -Seizures/tremors -Difficulty - Memory loss walking -Word finding -Slurred speech -Imbalance -Blurred vision -Incoordination -Confusion -Dizziness/light headedness -Jerking	HEMATOLOGIC/ LYMPHATIC -Swollen glands -Easy bruising -Excessive bleeding -Blood clots
RESPIRATORY -Frequent cough -Snoring -Wheezing -Sleep apnea -Shortness of breath -Coughing up blood	ALLEGIC/IMMUNOLOGIC -Allergy symptoms -Hives -Sinus pressure -Itching -Hives	OTHER_____ _____ _____ _____ _____

PATIENT SIGNATURE_____ DATE:_____