BRIGHAM AND WOMEN'S HOSPITAL
Specializing in care for a lifetime

HARVARD MEDICAL SCHOOL
TEACHING AFFILIATE

Department of Neurology

New Patient Intake Form **Date:** _____

I. Demographic Information

Name: _____ Date of Birth: _____ Age: _____ BWH MRN # _____

Home Address: _____

Home phone: _____ Cell Phone: _____

Email: _____

II. Care Information – please list complete name and address of physicians (VERY IMPORTANT)

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Referring Physician (if different from PCP): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Other Physicians (if different from above): _____ Specialty: _____

Address: _____ City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____ Email: _____

Pharmacy: _____ Address: _____

Phone: _____ Fax: _____City: _____ State: _____ Zip:_____

III. Reason for visit – Chief Complaint (History of Present Illness)
Please describe the major problem that brings you in today to see a Neurologist:

_____

_____

Is this visit related to worker's compensation? (circle one) Yes No
Is this visit related to any legal actions? (circle one) Yes No
If this problem is the result of an accident, when did the accident occur? _____

IV. Surgical History Please list all operations you have had: Date:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

V. Medical History Please list all active medical conditions: Duration:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:

Medication:	Dose:	Frequency:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please **LIST** all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

Are you taking any "blood thinning" medications? ☐ Yes – indicate below ☐ No
Aspirin or aspirin-containing medication ☐ Anti-inflammatory medication ☐ Plavix ☐
Coumadin ☐ Fish Oil ☐ Other: _____

VI. Social History

Occupation: _____ Marital Status: _____ Number of children: _____

Hobbies: _____

Do you smoke cigarettes? _____ If so, how many packs a day? _____
At what age did you start?_____ If applicable, at what age did you stop?_____
Do you drink alcohol?_____ If yes, how much daily? _____
At what age did you start?_____ If applicable, at what age did you stop?_____
Do you use recreational drugs?_____ Type? _____
Do you exercise regularly? (circle one) Yes No How frequently?_____
Weight: _____
Height: _____
Females: Are you, or could you be pregnant? (circle one) Yes No
Age at first full-term pregnancy _____ Age at first Menstrual Period? _____
Age at last menstrual period _____ Ever used Oral Contraceptives?_____
Ever used Hormone Replacement Therapy? _____

VII. Family History Do you have a family member affected with:

Condition	Yes	No	type/affected relative	Condition	Yes	No	type/affected relative
Brain Tumor	☐	☐		Muscle Disease	☐	☐	
Seizures or Epilepsy	☐	☐		Neuropathy	☐	☐	
Dementia	☐	☐		Other Neurological Disorder	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
Multiple Sclerosis	☐	☐		Diabetes	☐	☐	
Thyroid Disease	☐	☐		Migraines	☐	☐	

Write other conditions _____

VIII. Review of Symptoms Do you currently, or have you had a problem with:

Constitutional:	***Circle One***	
Fever	Yes	No
Weight loss >5 lbs	Yes	No
Excessive fatigue	Yes	No
History of Falls	Yes	No
Eyes:		
Wear glasses	Yes	No
Infections	Yes	No
Injuries	Yes	No
Glaucoma	Yes	No
Cataracts	Yes	No
Ear, Nose, Throat & Mouth:		
Wear hearing aid(s)	Yes	No
Hearing loss	Yes	No
Ear pain/infections	Yes	No
Ringing in ears	Yes	No
Nose bleeds	Yes	No
Nasal congestion/drainage	Yes	No
Inability to smell	Yes	No
Sinus problems	Yes	No
Balance (vertigo, spinning, etc.)	Yes	No
Cardiovascular:		
Chest pain or angina	Yes	No
High blood pressure	Yes	No
Irregular pulse	Yes	No
Heart murmur	Yes	No
High cholesterol	Yes	No
Swelling in hands or feet	Yes	No
Leg pain while walking	Yes	No
Respiratory:		
Asthma	Yes	No
Emphysema	Yes	No
Shortness of breath	Yes	No
Pneumonia	Yes	No
Bloody sputum	Yes	No
Gastrointestinal:		
Nausea	Yes	No
Vomiting	Yes	No
Blood in your vomit	Yes	No
Liver disease	Yes	No
Jaundice	Yes	No
Abdominal pain	Yes	No
Change in bowel habits	Yes	No
Ulcers or gastritis	Yes	No

Endocrine:	***Circle One***	
Diabetes	Yes	No
Thyroid disease	Yes	No
Excessive thirst/urination	Yes	No
Genitourinary:		
Urinary tract infections	Yes	No
Painful urination	Yes	No
Blood in your urine	Yes	No
Difficult starting/stopping stream	Yes	No
Incontinence	Yes	No
Kidney stones	Yes	No
Musculoskeletal:		
Broken bones	Yes	No
Arm or leg weakness	Yes	No
Arm or leg pain	Yes	No
Joint pain or swelling	Yes	No
Arthritis	Yes	No
Integumentary:		
Skin disease	Yes	No
Breast pain, tenderness, nipple discharge	Yes	No
Unusual moles	Yes	No
Neurological:		
Fainting spells or "black outs"	Yes	No
Headaches	Yes	No
Seizures	Yes	No
Problems with memory	Yes	No
Disorientation	Yes	No
Difficulty with speech	Yes	No
Inability to concentrate	Yes	No
Double or blurred vision	Yes	No
Weakness in arms and/or legs	Yes	No
Loss of sensation	Yes	No
Difficulty with balance	Yes	No
Psychiatric:		
Anxiety	Yes	No
Depression	Yes	No
Hematologic/Lymphatic:		
Anemia	Yes	No
Hemophilia	Yes	No
Blood transfusion	Yes	No
Persistent swollen glands/lymph nodes	Yes	No
HIV	Yes	No
Allergic/Immunologic:		
Food, Inhalant (nasal) allergies	Yes	No
Autoimmune disease (i.e., lupus)	Yes	No

VII. Pain Assessment

Do you experience pain as part of your daily life? (circle one) Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? _____

VIII. History of Falls

Have you had any significant falls in the past 6 months? Yes No

If yes, please explain: _____

IX. Nutrition Assessment

Have you experienced daily vomiting/diarrhea for more than two days? (circle one) Yes No

If yes, please explain: _____

Have you gained or lost 20 lbs in the last 3 months? Yes No

If yes, please explain: _____

Have you experienced nausea or poor appetite for more than five days? (circle one) Yes No

If yes, please explain:_____

X. Handedness

Are you (circle one): Left Handed Right Handed

XI. Safety

Did you receive a copy of a pamphlet titled, "We Care About Your Safety?" Yes No

Do you understand how to prevent the spread of germs? Yes No

If having surgery or procedure, do you understand how we will keep you safe? Yes No

Does anyone cause you to be afraid? Yes No

Do you have additional questions or concerns about patient safety?

_____

_____

XII. Do you have a Health Care Proxy? (circle one) Yes No

If yes, please list and bring copy: _____

If no, and you would like more information, please ask our receptionist.

The information on this form is accurate to the best of my knowledge:

_____ _____

Patient Signature Date completed

I have reviewed the above information with the patient:

_____ Clinical ID # | | | | | | _____

Physician Signature Date reviewed

Revised May 2009

Physician Initials _____

Please complete all pages