Mankato Clinic

NEUROLOGY PATIENT DATA BASE

Name _____ Date_____
Address _____City _____ State_____ Zip _____
DOB _____ Sex: M/F_____ Marital Status: _____ Occupation _____
Are you right or left handed? _____ Education _____
Illnesses: (As far as you know, have you ever had or been told you had)

			Date				Date
Stroke (or TIA)	Yes	No	_____	Arthritis	Yes	No	_____
High Blood Pressure	Yes	No	_____	Thyroid Disease	Yes	No	_____
Seizures	Yes	No	_____	Rheumatic Fever	Yes	No	_____
Migraine Headaches	Yes	No	_____	Asthma	Yes	No	_____
Diabetes	Yes	No	_____	Heart Attack	Yes	No	_____
Cancer	Yes	No	_____	Heart Failure	Yes	No	_____

FAMILY HISTORY:
Father: Age (now or at death) _____ Mother: Age (now or at death) _____
Medical Problems:
Father: _____ Mother: _____
Brothers: _____ Sisters: _____
Has any blood relative ever had: (please circle)

			Relationship				Relationship
Headaches	Yes	No	_____	Psychiatric Illness	Yes	No	_____
Seizures	Yes	No	_____	Stroke	Yes	No	_____
Blindness	Yes	No	_____	Multiple Sclerosis	Yes	No	_____
Deafness	Yes	No	_____	High Blood Pressure	Yes	No	_____
Muscle weakness	Yes	No	_____	Diabetes	Yes	No	_____
Muscle wasting	Yes	No	_____	Cancer	Yes	No	_____
Incoordination	Yes	No	_____	Heart Trouble	Yes	No	_____
Abnormal movements	Yes	No	_____	Thyroid Disease	Yes	No	_____
Dementia	Yes	No	_____	Intellectual Disability	Yes	No	_____
				Depression	Yes	No	_____

SURGICAL HISTORY: _____
_____

PERSONAL HISTORY: (*LAST 30 DAYS)*

Neurologic Review of System (Constitutional):	**(Circle)**		**Comments – Date of onset, if known**
Fever	Yes	No	_____
Chills/Night Sweats	Yes	No	_____
Malaise	Yes	No	_____
Fatigue	Yes	No	_____
Weight Gain	Yes	No	_____
Weight Loss	Yes	No	_____
Excessive Drowsiness	Yes	No	_____
Eyes:			
Changing Visual Acuity	Yes	No	_____
Double Vision	Yes	No	_____
Tearing	Yes	No	_____
Blurry Vision	Yes	No	_____
ENT:			
Decreased Hearing	Yes	No	_____
Ringing in Ears	Yes	No	_____
Ear Pain	Yes	No	_____
Sore throat	Yes	No	_____
Difficulty Swallowing	Yes	No	_____
Excessive Salivation	Yes	No	_____
Change in Sense of Taste	Yes	No	_____
Change in Sense of Smell	Yes	No	_____
Snoring	Yes	No	_____
Sinus Symptoms	Yes	No	_____
Cardiovascular:			
Chest Pain	Yes	No	_____
Palpitations	Yes	No	_____

Respiratory:

Shortness of Breath	Yes	No	_____
Cough	Yes	No	_____

Gastrointestinal:

Nausea	Yes	No	_____
Vomiting	Yes	No	_____
Heartburn	Yes	No	_____
Constipation	Yes	No	_____
Diarrhea	Yes	No	_____
Abdominal pain	Yes	No	_____
Change in Bowel Movements	Yes	No	_____

Genitourinary:

Change in Urination	Yes	No	_____
Change in Sexual Function	Yes	No	_____
Urinary Frequency	Yes	No	_____
Urinary Urgency	Yes	No	_____
Urinary Incontinence	Yes	No	_____

Musculoskeletal:

Difficulty Walking	Yes	No	_____
Cramps	Yes	No	_____
Joint Pain	Yes	No	_____
Neck Pain	Yes	No	_____
Loss of Balance	Yes	No	_____
Back Pain	Yes	No	_____
Weakness	Yes	No	_____
Loss of Muscle Bulk	Yes	No	_____
Flickering muscle Movements under the skin	Yes	No	_____
Joint swelling or stiffness	Yes	No	_____

Integumentary:

Skin Lesions	Yes	No	_____

Neurological:

Headache	Yes	No	_____
Pain	Yes	No	_____
Burning Sensation	Yes	No	_____
Numbness	Yes	No	_____
Confusion	Yes	No	_____
Incoordination	Yes	No	_____
Slurred Speech	Yes	No	_____
Light Headedness	Yes	No	_____
Involuntary Movements/tremors	Yes	No	_____
Memory Loss	Yes	No	_____
Vertigo (sense of spinning)	Yes	No	_____
Loss of Consciousness	Yes	No	_____

Psychiatric:

Insomnia	Yes	No	_____
Anxiety	Yes	No	_____
Depression	Yes	No	_____
Difficulty with Thinking	Yes	No	_____
Memory	Yes	No	_____
Mood Changes	Yes	No	_____
Difficulty with Irritability	Yes	No	_____
Difficulty with Comprehension	Yes	No	_____
Difficulty with Calculation	Yes	No	_____
Difficulty with Reading	Yes	No	_____
Difficulty with Writing	Yes	No	_____
Feeling Suicidal	Yes	No	_____

Endocrine:

Sweating	Yes	No	_____

Hematologic and Lymphatic:

Swollen Glands	Yes	No	_____
Easy Bruising of Skin	Yes	No	_____
Anemia	Yes	No	_____