Neuro Medical Care
ASSOCIATES, PLLC
52 Harrison St 2nd Floor Johnson City, New York 13790

Patient Name: _____ DOB: _____ Date: _____

Please check all prior and current medical problems, and state when diagnosed:

- ☐ Stroke _____
- ☐ Seizures _____
- ☐ Migraines _____
- ☐ Heart Attack _____
- ☐ High Cholesterol _____
- ☐ Thyroid disorder _____
- ☐ Sleep apnea _____
- ☐ Aneurysm or brain hemorrhage _____
- ☐ Chronic neck or back pain _____
- ☐ Neuropathy _____
- ☐ High blood pressure _____
- ☐ Irregular heart rhythm _____
- ☐ Diabetes _____
- ☐ Restless leg syndrome _____

OTHER:

Please indicate previous surgeries and date performed:

- ☐ Brain surgery _____
- ☐ Neck or back surgery _____
- ☐ Tonsil or adenoids removed _____

OTHER: _____

Please list all current medications, doses, and how you take them (example: three times a day, once a day, etc):

Chemo therapy or radiation therapy _____

Please list any medication allergies and reaction you had:

Tobacco use: please check any that apply:

☐ Cigarettes ☐ Cigars ☐ Chewing tobacco Number/packs smoked in a day: ☐ Years smoking or smoked in past ☐

Alcohol use: What kind: _____ Number of drinks/week: _____

Recreational drugs: _____

Employment/Profession: _____

Marital status: Please check one: Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow ☐ Children ☐ # of Children ____

Please list any medical problems of blood relatives:

Reviewed by: Dr. _____ Date: _____

Phone 607-729-1521 Fax 607-729-7320 www.neuromedical.org
Taseer Minhas, M.D., Dharmesh Patel, M.D., Aamir Rasheed, M.D., Ahmad Alwan, D.O., Sherrie Adler, FNP-C, Doreen Yirenchi, FNP-C

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Please check all that apply to you.

General
- ☐ Weight change
- ☐ Loss of appetite
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Swollen lymph glands

Eyes
- ☐ Blurred/Loss of vision
- ☐ Double vision
- ☐ Light sensitivity
- ☐ Eye pain

Ear, Nose & Throat
- ☐ Altered hearing
- ☐ Earache
- ☐ Ringing
- ☐ Hoarseness
- ☐ Sore throat
- ☐ Nasal congestion
- ☐ Facial pain

Cardiovascular
- ☐ Chest pain/Discomfort
- ☐ Shortness of breath
- ☐ Palpitations

Respiratory
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Coughing up blood

Gastro-intestinal
- ☐ Nausea/Vomiting
- ☐ Change in bowel habits
- ☐ Bloody stools

Genitourinary
- ☐ Frequency urinating
- ☐ Hesitation urinating
- ☐ Urgency
- ☐ Inability to empty bladder
- ☐ Lack of sexual drive

Musculoskeletal
- ☐ Muscle Aches
- ☐ Joint Pains
- ☐ Muscle Cramps
- ☐ Neck/Back pain
- ☐ Weakness

Skin
- ☐ Rashes
- ☐ Suspicious lesions
- ☐ Change in moles

Endocrine
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Excessive hunger

Immunologic
- ☐ Seasonal allergies
- ☐ Hives or rashes

Neurologic
- ☐ Headache
- ☐ Dizziness/Vertigo
- ☐ Fainting
- ☐ Transient loss of responsiveness
- ☐ Difficulty with speech
- ☐ Weakness
- ☐ Numbness
- ☐ Tingling
- ☐ Convulsions
- ☐ Tremors
- ☐ Difficulty with concentration
- ☐ Memory problems

Psychiatric
- ☐ Depressed
- ☐ Thoughts of suicide
- ☐ Anxiety
- ☐ Hallucinations

Sleep
- ☐ Snoring
- ☐ Stop breathing in sleep
- ☐ Insomnia
- ☐ Restless sleep or frequent awakenings
- ☐ Morning headache
- ☐ Nasal congestion
- ☐ Daytime sleepiness

Reviewed By: Dr._____ Date:_____

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