NEUROLOGY ASSOCIATES OF **PEARLAND**

Thank you for visiting pearlandneurology.com. Please complete the following paperwork before your appointment. This is a digital document which will allow you to type your information rather than complete it by hand.

Once completed, you may either save the document to your computer and email it to us at hello@pearlandneurology.com or print the document and bring it with you to your appointment.

If you do not feel comfortable completing this document, you may complete the documents at the office prior to your appointment. If you have any questions regarding this paperwork, please call us at (281) 835-4159.

NEUROLOGY ASSOCIATES OF PEARLAND

In addition to the fact sheet presented to you at every visit, we will request that you review and update this form at least once a year so we may maintain the most up-to-date and accurate information on our patients.

Patient Information

First Name _____ MI _____ Last Name _____ Date of Birth _____

Social Security No. _____ Sex: ☐ Male ☐ Female Marital Status: Select a marital status...

If patient is a minor: _____ _____
Parent or Legal Guardian's Name Date of Birth

Home Address _____ Apt # _____ City _____ State _____ Zip Code _____

Home Phone _____ ☐ Primary Number Mobile Phone _____ ☐ Primary Number Work Phone _____ ☐ Primary Number

Email Address _____

Race: Select a race... Ethnicity: Select an ethnicity...

Language: ☐ English ☐ Spanish ☐ Vietnamese ☐ Other: _____

Spouse's Name _____ Spouse's Mobile Phone _____ Spouse's Work Phone _____

Health Care Provider Information

Physician's Name _____ Physician's Phone _____ Who referred you to our office? _____

Emergency Contact Information

In case of emergency, whom should we contact? (This MUST BE someone other than you.) Please list all contact numbers.

Contact's Name _____ Relationship _____

Home Phone _____ Mobile Phone _____ Work Phone _____

Information Sharing

You may want to share your health information (treatment, lab results, prescriptions, etc.) with a relative or someone involved in your care. Please list the person that authorized by you to receive this information.

Contact's Name _____ Relationship _____

Pharmacy Information

Pharmacy Name _____ Phone _____

Mail Order Pharmacy Name _____ Phone _____

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Patient Name: _____

DOB: _____

What is the primary reason for your visit today? _____

Disease	Yes	No
Anemia		
Anxiety		
Asthma		
COPD		
Emphysema or chronic bronchitis		
Back problems		
Breast cancer		
Congestive heart failure		
Coronary artery disease		
Myocardial infarction		
Cardiac arrhythmia		
Depression		
Diabetes		
Glaucoma		
Headaches		
Heart disease		
High cholesterol		
High blood pressure		
Hyperthyroid		
Hypothyroid		

Disease	Yes	No
Kidney disease		
Urinary tract infections		
Kidney stones		
Liver disease		
Migraines		
Phlebitis/blood clots		
Psychiatric disorder		
Rheumatoid arthritis		
Seizures		
STDs		
Skin cancer		
Sleep apnea		
Gastric ulcer		
Stroke		
Other cancer		
Other:		
Other:		
Other:		
Other:		
Other:		

Surgical History	Date

Hospitalizations	Date

Family History: Please indicate in the spaces below any family member with a history of the diseases listed below.

	Father	Mother	Siblings	Children	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmother
Age (if living)								
Age (at death)								
Cause of death								
Alzheimer's disease								
Cancer								
Diabetes								
Heart attack								
High blood pressure								
Huntington's disease								
Migraines/headaches								
Multiple Sclerosis								
Parkinson's disease								
Seizures								
Stroke								
Other Illness								

Social History

Please indicate in the spaces below any family member with a history of the diseases listed below.

Relationship: Choose a relationship status...

Occupation: **Education:** Choose an option...

Do you smoke or use tobacco products? Yes No Quit

How many years did you smoke? _____

Do you drink alcohol? Yes No **How often?** Choose frequency...

Do you use recreational/street drugs? Yes No

If yes, which drugs? _____

How often? Choose frequency...

Allergies

Please indicate in the spaces any known allergies and reaction.

Allergy	Reaction

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Patient Name: _____

DOB: _____

Medications

Please list all current medications, prescription and non-prescription.

Medication	Dosage	Frequency
Example: *Aspirin*	*81mg*	*Once daily*

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Patient Name: _____

DOB: _____

Have you experienced any of the symptoms listed below in the last several weeks?

Symptom	Yes	No
Fever		
Shortness of Breath		
Weight loss > 10 pounds		
Coughing up blood		
Weight gain > 10 pounds		
Chest pain		
Trouble urinating		
Palpitations		
New rashes or bumps		
Joint deformity		
Breast lump		
Joint pain		
Changing skin lesions		
Change in thirst		
Inappropriate sadness or anxiety		
Diarrhea		
Easy bruising		
Change in vision		
Bleeding nose, ears, or mouth		
Constipation		
Mouth sores		
Abdominal pain		
Flank pain		

Symptom	Yes	No
Memory difficulty		
Face pain		
Thinking problems		
Pain in shoulders, arms or wrists		
Hallucinations		
Pain in hips, legs or feet		
Confusion		
Pain in neck		
Headaches		
Lower back pain		
Mid-back pain		
Seizures		
Difficulty speaking		
Bladder/Bowel control difficulty		
Difficulty swallowing		
Numbness in genitals or anus		
Double vision or loss of vision		
Excessive daytime sleepiness		
Loss of hearing		
Snoring		
Dizziness/Vertigo		
Tremor		
Numbness/Tingling of arms or legs		
Problems standing or balancing		
Numbness/Tingling of face		
Muscle tightening/spasm		
Weakness of hands, arms, or legs		
Muscles shrinking		

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