



CSNA

Comprehensive Neurosciences

Penrose Pavilion
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719-389-1191 **FX**
www.csneuro.com

Date: ___/___/___

Name: _____ Age: _____ Date of Birth: ___/___/___ Sex: M / F

Referring MD: _____ Primary MD: _____ Height: _____ Weight: _____ Right / Left Handed

How did you hear about us? Online Physician Referral Friend/relative Other: _____

Please list conditions / diseases you wish to have checked at this examination:

MEDICATIONS: (Please list medications & dosages)	

ANY BLOOD THINNERS: Coumadin Plavix Aspirin Other: _____

ALLERGIES: (Please list any allergies to medications) _____

CONDITIONS: (Please mark any conditions you have or had in the past)

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> AIDS / HIV | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Alcohol problems | <input type="checkbox"/> Cancer | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Sciatica |
| <input type="checkbox"/> Appendicitis | <input type="checkbox"/> Carpal Tunnel Syndrome | <input type="checkbox"/> Gout | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Arm pain | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Stroke / TIA |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Depression | <input type="checkbox"/> Hernia | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Bipolar Disorder | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate problem | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breast lump | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Ulcers |

MAJOR ILLNESSES, SURGERIES, or HOSPITALIZATIONS:

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

_____ Year: _____

OCCUPATIONAL CONCERNS:

Have you filed a Work Injury report with your employer?

YES / NO

Date of injury: ___/___/___

Is there a lawsuit planned that relates to the current medical problem?

YES / NO

Your occupation: _____ Marital Status: _____

HEALTH HABITS

Tobacco Yes / No Packs per day: _____

Alcohol Yes / No Drinks per day: _____

Recreational Drugs Yes / No

FAMILY HISTORY

Father – Age: ____ Condition of health: _____ Deceased at age: ____ Cause of death: _____

Mother – Age: ____ Condition of health: _____ Deceased at age: ____ Cause of death: _____

Any significant illnesses in the family: _____

Constitutional Symptoms: (Please mark any symptoms that you may have)

GENERAL

- Fever
- Fatigue
- Loss of appetite
- Significant weight loss

OPHTHALMOLOGY

- Vision loss
- Blurring of vision
- Double vision

GASTROENTEROLOGY

- Abdominal pain
- Heartburn
- Nausea
- Vomiting
- Blood in stool

DERMATOLOGY

- Itching
- Redness
- Lumps
- Rash
- Skin cancer

HEMATOLOGY

- History of transfusion
- Easy bruising

MUSCULOSKELETAL

- Joint pain
- Joint swelling
- Joint stiffness
- Muscle aches

ENDOCRINOLOGY

- Excessive sweating
- Excessive thirst
- Temperature intolerance
- Lactation

ENT / RESPIRATORY

- Hearing loss
- Ringing in ears
- Shortness of breath
- Sleep apnea
- Cold and cough
- Change in voice
- Difficulty swallowing

PSYCHOLOGY

- Anxiety
- Depression
- Sleep disturbances
- Hyperactivity
- Attention deficit

NEUROLOGY

- Headache
- Memory problems
- Tremors
- Balance difficulty
- Numbness
- Weakness
- Speech problems
- Dizziness
- Seizures

CARDIOLOGY

- Chest pain
- Palpitations / irregular heartbeat
- Leg swelling
- History of heart attack
- Atrial fibrillation

GENITOURINARY

- Difficulty urinating
- Urinary urgency
- Increased urinary frequency
- Urinary incontinence

NOTES:

Please list the physicians to whom you would like for us to send a report:

- _____
- _____
- _____
- _____

Patient signature: _____