Neurological Associates of Long Island, P.C.

Patients Name_____
Patient's Signature_____
Today's Date _____

Please answer all questions completely. Do not leave any blanks

Please describe the reason for your visit today: _____
_____

Is your condition a result of a work related injury? Yes ___ or No____
Is your condition a result of a motor vehicle accident? Yes___ or No_____
Please list the medications you are currently taking including prescription medications, over the counter, herbal remedies and vitamins. Please include dosage and how often they are taken:

_____
_____

Do you have any allergies? Yes or No If yes, please list_____
Do you have diabetes? Yes or No If yes, for how long? _____
Do you have high blood pressure? Yes or No If yes, for how long? _____
Do you have a Pacemaker? Yes or No
Have you had any falls in the past 12 months? Yes or No If yes, **How Many?** _____
Are you experiencing any pain? Yes or No
Please describe any problems/conditions you have or have had with:
Heart_____
Lungs_____
Kidneys/Prostate_____
Stomach/Bowels_____
Thyroid_____
Eyes_____
Ears_____
Immunologic_____
Psychiatric_____
Please describe any other medical problems you have or have had:
_____
Please list any operations or hospitalizations (with dates)
_____
Are you a tobacco user? Yes or No What Kind? _____How much? _____
Do you drink alcohol/beer/wine? Yes or No How much? _____
Any Significant Family History? _____
Do You Have an Advanced Directive? Yes or No

Race_____ Ethnicity _____Primary Language_____

Doctor's Signature: _____
Today's Date: _____

Please use back of form if additional space is needed