BOCA RATON NEUROLOGIC ASSOCIATES

NAME: ______________________________

Please provide us with written medication list.

Drug Allergies: ____

____

Name and Phone of the Pharmacy ____

PAST MEDICAL HISTORY: (circle any medical problems that you have had) :

Pacemaker Seizures Stroke Depression Heart Attack Stents

Migraines High Blood Pressure High Cholesterol Atrial Fibrillation

Emphysema / COPD Asthma Seasonal Allergies Liver Disease

Kidney Disease Diabetes Thyroid Reflux Ulcers Colon Polyps

Anemia Bleeding Arthritis Depression Osteoporosis

Blood Clots Prostate Back or Neck Surgery Carpal Tunnel/ Surgery

Cancer, Type _________________ Other __________________________________

____

PRIOR SURGERIES: ____

____

FAMILY HSITORY: (List any diseases in your family and their relation to you)

____

____

Signature:_______________________________ Date: ______________

(561) 338-8484 (561) 338-8492 (fax)
Boca Raton Medical Plaza, 1050 NW 15th St., Suite 216A Boca Raton, Florida 33486

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REVIEW OF SYMPTOMS

Please circle below if you have had any of these symptoms in the last two weeks:

General: fever / chills/ unexplained weight loss or weight gain / poor appetite

Neuro: Poor Balance / Numbness / Headaches/ Lightheadedness / Weakness on one side

Head/ Eyes: vision changes / hearing problems / swallowing issues / sore throat

Cardiac: chest pain / palpitations / dizziness / loss of consciousness

Respiratory: cough/ shortness of breath / wheezing

Gastro: abdominal pain / nausea / vomiting / diarrhea / constipation

Urinary: pain on urination / retention / incontinence

Skeletal: pain in joints / swelling in joints / neck pain / back pain

Skin: rashes / sores / wounds

Endocrine: heat or cold intolerance / hair loss

Hematologic: easy bleeding or bruising/ recent transfusions / recent chemo or radiation

Psychiatric: depression / anxiety

Do You Smoke ? ___ Yes ___ No Did You Ever Smoke ? ____ Yes ____ No When? _______

Drug Use? ___Yes ____ No If yes, Type__________________ Current? ____

Safety Questions:

Have you had more than 2 (two) falls in the last year? _____ Yes _____ No

Do you have concerns about your driving? _____ Yes _____ No

Do you feel safe in your own home? _____ Yes _____ No

Signature:________________________________ Date: _______________

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