

NEUROLOGY-NEW ADULT PATIENT VISIT FORM

Department of Neurology
 1633 Medical Center Point, Colorado Springs, CO 80907



Patient Name: _____ DOB: _____ Today's Date: _____

Referring Provider: _____ Primary Care Provider: _____

Please list below all medications that you are currently taking (or provide a list):

Name of Medicine	Dose	Frequency	Prescribed by/Other Info
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			

List any allergies to medications, IV dyes, or foods: _____

SOCIAL HISTORY Married Divorced Single Widowed Separated

HABITS

Cigarettes/Cigars No Yes, pks/day _____ Street Drugs No Yes, name _____

Alcohol No Yes, drinks/day ____ drinks/week _____ Caffeinated Drinks No Yes, ____ drinks/day

FAMILY HISTORY

If any blood relative has suffered any of the following, please place a check by it and indicate which relative.

- Epilepsy (seizures) _____ Stroke _____
- Migraine headaches _____ Alcoholism _____
- Mental illness _____ Genetic disease _____
- High cholesterol _____ Cancer _____
- Heart disease _____

PREVIOUS HOSPITALIZATIONS AND/OR SURGERIES

Year	Illness or Operation	Year	Illness or Operation
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please place a check by any of the following symptoms that you have had in the last 3 months:

Constitutional:	<input type="checkbox"/> Weight Loss	<input type="checkbox"/> Weight Gain	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Fever
Eyes:	<input type="checkbox"/> Worsening Vision	<input type="checkbox"/> Double/Blurry Vision		
Musculoskeletal:	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Numbness/Tingling	<input type="checkbox"/> Back Pain – Frequent	
	<input type="checkbox"/> Joint Pain	<input type="checkbox"/> Neck Pain		
Respiratory:	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Shortness of Breath		
Neurologic:	<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Tremor/Hand Shaking	<input type="checkbox"/> Headache	
Genitourinary:	<input type="checkbox"/> Bladder Incontinence	<input type="checkbox"/> Urgency	<input type="checkbox"/> Frequency	
Psychiatric:	<input type="checkbox"/> Nervousness/Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Memory Loss	
Cardiovascular:	<input type="checkbox"/> Chest Pain or Tightness	<input type="checkbox"/> Palpitations		
Heme/Lymph:	<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Swollen Glands	
Skin:	<input type="checkbox"/> Rash	<input type="checkbox"/> Hives		
Gastroenterology:	<input type="checkbox"/> Loss of Appetite	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Persistent Nausea
	<input type="checkbox"/> Persistent Vomiting	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Constipation	<input type="checkbox"/> Bloody Stool
Endocrine:	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Last Menstrual Period: _____	
HENT:	<input type="checkbox"/> Sinus Pain	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Decreased Hearing	
	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Change in Taste or Smell		
Sleep:	<input type="checkbox"/> Snoring – Loud	<input type="checkbox"/> Change in Sleep		

DaVita Medical Group - Medical Center Point



*map not to scale

1633 Medical Center Point

Located on the northwest corner of Fillmore & Union

