OPTUM®

Department of Neurology
1633 Medical Center Point
Colorado Springs, CO 89097

Neurology–new adult patient visit form

_____ _____ / _____ / _____ _____ / _____ / _____

Patient's name Date of birth 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 information
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, check applicable box(es) 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 surgery	Year	Illness or surgery
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Constitutional	☐ Weight loss	☐ Weight gain	☐ Fatigue	☐ Fever
Eyes	☐ Worsening vision	☐ Double/Blurry vision		
Musculoskeletal	☐ Muscle weakness ☐ Joint pain	☐ Numbness/Tingling ☐ Neck pain	☐ Back pain–frequent	
Respiratory	☐ Chronic cough	☐ Shortness of breath		
Neurologic	☐ Convulsions/Seizures	☐ Tremor/Hand shaking		☐ Headache
Genitourinary	☐ Bladder incontinence	☐ Urgency	☐ Frequency	
Psychiatric	☐ Nervousness/Anxiety	☐ Depression	☐ Memory loss	
Cardiovascular	☐ Chest pain or tightness		☐ Palpitations	
Heme/Lymph	☐ Anemia	☐ Easy bruising	☐ Swollen glands	
Skin	☐ Rash	☐ Hives		
Gastroenterology	☐ Loss of appetite ☐ Persistent vomiting	☐ Heartburn ☐ Diarrhea	☐ Abdominal pain ☐ Constipation	☐ Persistent nausea ☐ Bloody stool
Endocrine	☐ Diabetes	☐ Thyroid disease	☐ Last menstrual period: _____/ _____/ _____	
HENT	☐ Sinus pain ☐ Ringing in ears	☐ Hoarseness ☐ Change in taste or smell	☐ Decreased hearing	
Sleep	☐ Snoring–loud	☐ Change in sleep		

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