Seton Brain & Spine Institute
NEUROLOGY

A member of the Seton Family of Hospitals

6811 Austin Center Blvd, Suite 420, Austin, TX 78731
Tel: 512-324-2715 Fax: 512-324-2716

New Patient Information Form

Date:_____ My appointment is with Dr._____

Patient Name:_____DOB:_____

Name of Primary Care Physician:_____

Reason for see the doctor today:_____

Referring Physician:_____Phone #:_____

History of Present Illness:

Briefly describe your current symptoms or problems; _____

_____

How severe are the symptoms? _____

When did the symptoms originally started? _____

How often do the symptom occur? _____

How long do the symptoms last? _____

What makes the symptoms worse? _____

What measures or drugs relieve the symptoms? _____

What treatment, if any, have you received for this problem? _____

Past Medical History:

Do you have a history of (circle all that apply):

High blood Pressure	High Cholesterol	Heart Disease
Stroke	Migraines	Aneurysm
Diabetes	Cancer	Lung Disease
Multiple Sclerosis	Seizures	Neuropathy

Other_____

Circle one: Right Handed Left Handed Ambidextrous

Seton Brain & Spine Institute
NEUROLOGY
A member of the Seton Family of Hospitals

Past Surgical and Hospitalization History

Date

_____
_____
_____
_____

Medications

Please list your current medications and doses. Use back page if necessary. If you have a medication list, please attached here.

_____
_____
_____
_____
_____
_____
_____

Allergies

Name of Drug Reaction

_____
_____
_____
_____

Social History

Occupation:_____ If retired, last occupation:_____

Do you drink caffeinated beverages? Yes No About _____ per day

Do you use tobacco products? Yes No About _____ packs per day

Do you drink alcohol? Yes No About _____ drinks per day

Do you or have you used street drugs? Yes No If yes, type of drug_____

Seton Brain & Spine Institute
NEUROLOGY
A member of the Seton Family of Hospitals

Family History

Does anyone in your family have a history medical problems? (If so, please explain)

Mother:_____

Father:_____

Brother(s):_____

Sister(s):_____

Children:_____

Grandparents:_____

Current weight: **Height:**

Seton Brain & Spine Institute
NEUROLOGY
A member of the Seton Family of Hospitals

Please circle the symptom or symptoms that you currently have or have had in the last six months. If you don't have any symptoms, please circle no symptoms.

General:
Fever
Chills
Weight loss
Weight gain
Fatigue
Syncope
Excessive sweating
Depression
Anxiety
No Symptoms

Eyes/Ears:
Change in vision
Blurred vision
Double vision
Loss of hearing
Ringing of the ears
Earaches
No Symptoms

Throat/Sinus:
Difficulty swallowing
Sore throat
Nasal pain
Nose bleeds
No Symptoms

Neck:
Neck stiffness
Swollen lymph nodes
No Symptoms

Pulmonary:
Shortness of breath
Dry cough
Productive cough
Pneumonia
No Symptoms

Cardiac:
Chest pain
Palpitations
Hypertensions
Heart murmur
No Symptoms

Vascular/Hematologic:
Swollen legs
Blood clots
Anemia
Easy bruising or bleeding
Transfusions
No Symptoms

GI:
Stomach pain
Constipation
Diarrhea
Hepatitis
No Symptoms

Urinary:
Frequency
Incontinence
Infections
No Symptoms

Musculoskeletal:
Muscle aches
Joint pain
No Symptoms

Neurological:
Headache
Seizure
Stroke
Weakness
Tremor
Imbalance
Falls
No Symptoms

Other:
_____
_____
_____
_____

For Office Use Only:

_____ _____
Initials Date