



Seton Brain & Spine Institute NEUROLOGY

A member of the Seton Family of Hospitals

1600 West 38th Street Ste 308
Austin, Texas 78731

New Patient Information Form

Medical History

Date: _____ My appointment is with Dr _____

Patient Name: _____ DOB: _____

Name of Primary Care Physician: _____

Reason for see the doctor today: _____

Referring Physician : _____ Phone Number: _____

Circle one: Right Handed Left Handed Ambidextrous

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 _____

Family History

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

Mother: _____

Father: _____

Brother(s): _____

Sister(s): _____

Children: _____

Grandparents: _____



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 _____

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
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Past Surgical and Hospitalization History

Date

Immunizations (with year received)

Tetanus _____
Pneumovax _____

Influenza _____
Hepatitis B _____

Other _____
TB skin test _____

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