ATHENS
NEUROLOGICAL
ASSOCIATES
1088 A Baxter Street, Athens, GA • 706-353-0606

Athens Neurological Associates History and Physical

Patient Information

Chart Number: _____Date: _____ Preferred Pharmacy: _____

Full Name: _____ Age : _____

Right-handed Left-handed (please circle one)

Referred by: _____

Primary Care Provider : _____

Chief Complaint: What is your main problem?

History of Present Illness:
What/where is the problem? Please describe:

How long have you had the problem?
When do symptoms occur?
How often do symptoms occur and how long do they last?
What makes the problem better/improves symptoms?
What makes the problem worse?
How severe is the problem?
How many days of school/work have you missed due to this?
Other:

Tests: What lab tests, x-rays, etc. have you had done related to your main problem?

Past Medical History (if extra space needed, please request an additional page)
Medical Problems: please list all of your other medical problems an when you were diagnosed

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Previous hospitalizations/surgeries:

Reason: Date: Location:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

GYN:

Last menstrual period:_____ Date of menopause: _____

Number of pregnancies: _____ Number of miscarriages:_____

Number of births: _____ Last PAP smear and mammogram and results: _____

Medications: including all prescriptions/vitamins/birth control/hormones/over-the-counter medications, their dosage, and how many times you take them per day

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____

Drug allergies: list allergies and you type of reaction to it

1. _____
2. _____
3. _____

Family History:

Mother: Living /Deceased Age of death Medical problems

_____

Father: Living /Deceased Age of death Medical problems

_____

Family history continued on next page

Siblings (list): Living /Deceased Age of death Medical problems

_____

_____

_____

Children (list): Living /Deceased Age of death Medical problems

_____

_____

_____

Please list any other medical conditions that run in your family:

Social History (Adult Patients Only – Pediatric Patients go to next page):

Occupation:_____ Highest level of education: _____
Please circle one:
Married Single Divorced Widowed Separated Other:

Important activities/hobbies:
Do you smoke/did you ever smoke?_____ If yes, how many packs per day?_____

Did you quit smoking?_____ When? _____

Do you drink alcohol?_____ If yes, what and how much?_____

Do you drink caffeine? _____ If yes, what and how much?_____

Other drug use: _____
Is there a lawsuit regarding your current problem or is the problem possibly related to a car accident?

Child Development (Pediatric Patients Only – Adult Patients go to last question on page):
Please indicate the approximate age your child performed each of the following:

Smiled: _____ Rolled over: _____ Sat up without help:_____ Walked: _____ Walked up stairs: _____

Spoke first words: _____ Spoke words besides Mama or Dada: _____ Was potty trained: _____

<u>Has the child ever . . .</u>

Had a seizure?	Yes	No
Suffered a head trauma?	Yes	No
Had Meningitis or encephalitis?	Yes	No
Used alcohol or drugs?	Yes	No
Been physically, sexually or emotionally abused?	Yes	No

Birth History *(Pediatric Patients Only)*:

Birth weight: _____

Problems with pregnancy:

Infection Fever High blood pressure Diabetes Smoked

Drank alcohol Used street drugs

Delivery:

Vaginal Cesarean (C-Section)

Problems with delivery?

No Yes

Birth was:

Full term Late Early Week gestation

Social History *(Pediatric Patients Only- Adult Patients go to last question on page)*:

Current grade placement: _____ Grades repeated:_____ Name of School: _____

Does patient receive physical therapy? No Yes

Occupational therapy? No Yes

Speech therapy? No Yes

Mother: Age:_____ Occupation: _____ Married / Single / Divorced / Separated (circle one)

Father: Age: _____ Occupation: _____ Married / Single / Divorced / Separated (circle one)

Please tell us anything else about *yourself or your condition* that we may need to know:

Constitutional	**Ears, Nose, Mouth, Throat**	**Cardiovascular**	**Gastrointestinal**
Altered Taste/Smell	Balance Problems	Angina	Abdominal Pain
Change in Appetite	Allergies/Hay Fever	Chest Pain	Indigestion
Weight Loss	Ringing in My Ears/Innitus	Chest Pressure	Diarrhea
Weight Gain	Hearing Loss	Fainting	Gastritis
Unable to Sleep	Trouble Breathing Through	Heart Failure	Hapeatitis
Excessive Sleepiness	Nose	High Blood Pressure	Hiatal Hernia
Fatigue	Sinus Disease	Low Blood Pressure	Rectal Bleeding
Unexplained Fever	Mouth Sores	Shortness of Breath	Ulcer
Abnormal Growth	Sore Throat	Legs Swelling	Vomiting
Lost Interest in Activities	Trouble Swallowing	Coronary Disease	
Birthmark	Snoring		

Heme-Lymphatic
Blood Disorder
Diabetes
Sickle Cell Disease
Thyroid Disease
Enlarged Lymph Nodes
HIV
AIDS

Psychiatric
Anxiety
Depression
Trouble Concentrating
Hallucinations (Seeing/ Hearing Things)
Schizophrenia
In Trouble at School
Shy

Respiratory
Bronchitis
Emphysema
Pneumonia
Tuberculosis
Chronis Cough
Asthma

Eyes
Blurred Vision
Double Vision
Glaucoma
Cataracts
Loss Of Peripheral Vision
"Floaters"
Macular Degeneration

Musculoskeletal
Low Back Pain
Joint Pain
Joint Swelling

Genitourinary
Urine Incontinence
Stool Incontinence
Sexual Dysfunction
Constipation

Integumentary
Breast Disease
Skin Rash/Eczema
Melanoma
Basal Call Cancer

Endocrine
Allergic/Immonologic

Neurological Complaints
Dizziness
Facial Numbness/Tingling
Choking
Difficulty Sleeping
Hallucination
Numbness-Arms
Numbness-Legs
Swallowing Problems
Headache
Nausea

Difficulty Tasting
Trouble With Smell
Memory Problems
Poor Coordination
Drooling
Seizures/Convulsions
Personality Change
Speech Difficulty
Trouble Walking
Head Trauma

Weakness (Where?)
Stiffness
Vertigo
Spells/Fits
Pain
Difficulty Chewing
Difficulty Concentrating
Confusion
Aggressive

Clumsy or Poor Coordination
Fainting or Passing Out
Hostile/Angry
Speech Problems
Stares Off Into Space
Tremor
Trouble Hearing
Trouble Learning

All Patients - System Review
(Please indicate any conditions you have experienced in the past month NOT already detailed above)

Physician or Nurse Practitioner signature: _____ Date: _____

Physical Exam Notes (MD or NP to complete)

Vital Signs: T_____ BP _____ P_____ R_____ Wt _____ Ht _____

General Exam Notes:

Neurological Examination Notes:

Mental Status (A&O, language, knowledge, concentration, MMSE etc):

Cranial Nerves:

Fundus:

CV (auscultation, carotids, peripheral pulses):

Pulm:

Motor (strength, tone, ROM):

Sensory:

Coord/Cerebellar:

Gait:

DTR's:

Counseling/Coordination of Care Time – with ≥ 50% FTF time* (circle if applicable)

40minutes (level 3) 60 minutes (level 4) 80 minutes (level 5)

**Face to face time spent discussing issues with the patient and/or family as described above*

Assessment

1. _____
2. _____
3. _____
4. _____

Plan

1. _____
2. _____
3. _____
4. _____

Signature: _____ Date: _____