CONTEMPORARY
NEUROLOGY
GENA L. ROMANOW MD PC

5500 Knoll North
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t: 410.772.8020
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ContemporaryNeurology.com

Patient intake form

Name _____ Date of Birth _____ Todays Date _____

Phone contact _____ Email _____

Reason for seeing the doctor: _____

_____

Other medical conditions _____

MEDICATION NAME	DOSE	NUMBER OF PILLS	TIMING	REASON	PRESCRIBER

Medication allergies _____

Pharmacy Name and Number _____

Which doctors would you like to get reports of today's visit? _____

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Do you smoke? Y/N For how long? _____ When did you quit?_____

How much alcohol do you drink? _____

Review of Systems: Please circle any of the symptoms you have

Constitutional
Fever
Weight loss
Weight gain
Falls

Eyes
Double vision
Light sensitivity
Vision blacking out
Eye pain
Eye lids drooping

Heart
Rapid heart rate
Heart rate fluctuations
Light headedness
Irregular heart beat

Gastrointestinal
Nausea
Vomiting
Diarrhea
Constipation
Blood in stool
Stomach pain
Bowel incontinence

Head and Neck
Sore throat
Difficulty swallowing
Difficulty holding head up
Difficulty with sense of smell

Genitourinary
Urinary frequency
Urinary incontinence
Sexual dysfunction

Musculoskeletal
Pain in joints
Red/inflammation in joints
Pain in muscles
Muscles getting smaller
Fluttering sensation in muscles

Mood
Depression
Anxiety
Mood disorder
Hallucinations
Panic disorder
ADHD/ ADD

Chest and lungs
Shortness of breath
Asthma
Frequent choking sensation

Neurological
Headache
Weakness in one limb
Difficulty with coordination
Difficulty with speaking
Tingling in arms or legs
Unsteadiness in walking

Blood system
Easy bruising
Easy bleeding
History of blood clots in you or in family

Sleep
Partner notes stopping breathing in sleep
Insomnia
Excessive sleepiness
Movements in sleep
Acting out dreams

Patient Signature _____ Date _____

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Please fill out if here to discuss headaches

When did the headaches start? _____

On average, how many headaches do you experience per month? _____

How long do they usually last? _____

How do you describe the pain? *Select all that apply*

- Sharp
- Throbbing
- Dull
- Stabbing
- Other

On a scale of 1 to 10, how bad is the pain? (10 being the worst) _____

Have you experienced any of the following with your headaches? *Select all that apply*

- Nausea
- Vomiting
- Sensitivity to light
- Sensitivity to sound
- Tearing from eyes
- Nose dripping
- None of these
- Other

What medications (including over-the-counter medications and prescriptions) or treatments have you tried for your headaches and /or migraines? *Please list the dose and the duration of each medication.*

_____

_____

How many times a week do you have a headache that requires medication? _____

What makes your headache worse? _____

What makes your headache better? _____