SHORE PHYSICIANS GROUP℠

Neurology
52 E New York Ave, Somers Point, NJ 08244
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Dr Ravi Yangala, MD, DM **Dr Joshua Daniel, MD**
Board Certified Neurologist

Patient Name: _____ Referring Physician:_____
Date of Birth: _____ Preferred pharmacy:_____
Preferred lab:_____

Medical History

Current Complaint
Please briefly describe the reason for your visit to our office today:

_____
_____

Names of previous treating physicians[Neurologist/PCP]: _____
_____

Previous tests [Head CT, Brain MRI, Cervical/Thoracic/Lumbar MRI/EEG/EMG: (location and dates)]:

_____
_____

Current Medications:
Please list **all** current medications and doses (including over the counter):

_____
_____
_____
_____
_____
_____

Do you have any allergies to medications? ❑ Yes ❑ No
If yes, please list: _____
Have you had any chronic or serious illness? ❑ Yes ❑ No
If yes, please explain:_____
Have you had any neurological diagnosis? (stroke, epilepsy, multiple sclerosis, migraine, Parkinson's) ❑ Yes ❑ No
If yes, please explain: _____
_____
Have you been hospitalized or had any operations? ❑ Yes ❑ No
(ie: stroke, diabetes, heart disease, headaches, cancer, Parkinson's disease, Alzheimer's disease, Multiple Sclerosis, Seizures)
If yes, please indicate: Date/Hospital/City/State/Reason
_____

Handedness: ❑ Right ❑ Left ❑ Both

Smoking & Drug History

Have you ever smoked?	❑ Yes	❑ No
Do you presently smoke?	❑ Yes	❑ No

If you smoke, indicate how much of each kind per day:
Cigars:_____ Pipes:_____ Cigarettes:_____
If you smoke now, or did so previously, for how many years did you smoke?_____
If you have quit smoking, how long has it been since you stopped?_____
Do you drink alcoholic beverages, if so, what & how much?_____
Do you drink caffeinated beverages, if so, what & how much?_____
If you use recreational drugs, please notify the physician.

Family Medical History:
(ie: stroke, diabetes, heart disease, headaches, cancer, Parkinson's disease, Alzheimer's disease, Multiple Sclerosis, Seizures)

Mother:_____ Brother/Sister:_____
Father:_____ Children:_____
Grandparent:_____

Past medical History:

❑ Y	❑ N	ADD or ADHD	❑ Y	❑ N	Hypertentsion
❑ Y	❑ N	Allergies	❑ Y	❑ N	Infectious Disease
❑ Y	❑ N	Alzheimer's/Dementia	❑ Y	❑ N	Insomnia
❑ Y	❑ N	Anemia or Blood Disorder	❑ Y	❑ N	Kidney Stones
❑ Y	❑ N	Arthritis	❑ Y	❑ N	Liver Disease
❑ Y	❑ N	Asthma	❑ Y	❑ N	Lung Disease
❑ Y	❑ N	Birth Defects or Inherited Disease	❑ Y	❑ N	Muscle, Joint, or Bone Problems
❑ Y	❑ N	Congestive Heart Failure	❑ Y	❑ N	Narcolepsy
❑ Y	❑ N	COPD	❑ Y	❑ N	Nasal Septal Deviation
❑ Y	❑ N	Cancer	❑ Y	❑ N	Neck Pain/Injury
❑ Y	❑ N	Cholesterol Evaluation	❑ Y	❑ N	Neurological Conditions
❑ Y	❑ N	Constipation	❑ Y	❑ N	Neuropathy
❑ Y	❑ N	Coronary Artery Disease	❑ Y	❑ N	Obstructive Sleep Apnea
❑ Y	❑ N	Diabetes or High Blood Sugar	❑ Y	❑ N	Osteoporosis
❑ Y	❑ N	Dizziness/Fainting Spells	❑ Y	❑ N	Other/Not Listed
❑ Y	❑ N	Ear or Hearing Problems	❑ Y	❑ N	Parkinson's Disease
❑ Y	❑ N	Eczema, Hives or Other Skin Conditions	❑ Y	❑ N	Psychiatric Illness
❑ Y	❑ N	Erectile Dysfunction	❑ Y	❑ N	Repetitive Motion Injury
❑ Y	❑ N	Fibromyalgia	❑ Y	❑ N	Restless Leg Syndrome
❑ Y	❑ N	Fractures	❑ Y	❑ N	Seizure/ Epilepsy
❑ Y	❑ N	GERD/Reflux	❑ Y	❑ N	Serious Illness or Injuries
❑ Y	❑ N	Gout	❑ Y	❑ N	Shingles
❑ Y	❑ N	Head Trauma/Concussion	❑ Y	❑ N	Sinusitis
❑ Y	❑ N	Headache or Migraines	❑ Y	❑ N	Stroke
❑ Y	❑ N	Hearing Conditions	❑ Y	❑ N	Thyroid Problems
❑ Y	❑ N	Hepatitis	❑ Y	❑ N	Tuberculosis
❑ Y	❑ N	Hernia	❑ Y	❑ N	Vascular Disease
❑ Y	❑ N	Hospitalized or had any Operations	❑ Y	❑ N	Vision or Eye Problem

Recent Mammogram(Location and date)_____

Recent Colonoscopy (Location and date)_____

Influenza Vaccine (Location and date)_____

Pneumonia Vaccine (Location and date)_____

Review of Systems
Please place "X" in appropriate column

	Now	Prior	Never
A. Neurological			
Frequent Headaches	_____*	_____	_____
Loss of vision	_____	_____	_____
Double vision	_____	_____	_____
Speech change or loss	_____	_____	_____
Weakness in arms or legs	_____	_____	_____
Tremor or shaking	_____	_____	_____
Numbness in extremities	_____	_____	_____
Numbness of the face	_____	_____	_____
Dizziness	_____	_____	_____
Convulsions (seizures)	_____	_____	_____
Stroke	_____	_____	_____
Memory Loss	_____	_____	_____
Nervous breakdown	_____	_____	_____
Balance problems	_____	_____	_____
Trouble Swallowing	_____	_____	_____
Neck Pain	_____	_____	_____
Back Pain	_____	_____	_____
*if yes please complete headache questionnaire			
B. Eyes			
Blurry Vision	_____	_____	_____
Cataracts	_____	_____	_____
C. Ears, Nose & Throat			
Hearing Loss	_____	_____	_____
Hoarseness	_____	_____	_____
Ringing in ears	_____	_____	_____
Airborne allergies	_____	_____	_____
D. Respiratory			
Chronic Cough	_____	_____	_____
Shortness of breath	_____	_____	_____
E. Cardiovascular			
Fainting	_____	_____	_____
Heart murmur	_____	_____	_____
High blood pressure	_____	_____	_____
Chest pain or tightness	_____	_____	_____
Heart attack	_____	_____	_____
Palpitations	_____	_____	_____
History of irregular pulse	_____	_____	_____
F. Gastrointestinal			
Decreased appetite	_____	_____	_____
Diarrhea	_____	_____	_____
Bleeding	_____	_____	_____
Constipation	_____	_____	_____
Trouble swallowing	_____	_____	_____

	Now	Prior	Never
G. Genitourinary			
Pain when voiding	_____	_____	_____
Frequent urination	_____	_____	_____
Dribbling after urination	_____	_____	_____
Blood in urine	_____	_____	_____
Trouble voiding	_____	_____	_____
Incontinence	_____	_____	_____
H. Endocrine			
Diabetes	_____	_____	_____
Goiter or thyroid disorder	_____	_____	_____
I. Musculoskeletal & Skin			
Arthritis (note joints)	_____	_____	_____
Rashes	_____	_____	_____
Easy Bruising	_____	_____	_____
J. General			
Weight Loss (how much?)	_____	_____	_____
Weight gain (how much?)	_____	_____	_____
Fevers	_____	_____	_____
Shaking chills	_____	_____	_____

Do you have any trouble sleeping?	❑ Y	❑ N
Falling asleep?	❑ Y	❑ N
Staying asleep?	❑ Y	❑ N
Do you snore loudly?	❑ Y	❑ N
Do you commonly feel anxious?	❑ Y	❑ N
Do you usually feel depressed?	❑ Y	❑ N
If female, are you pregnant?	❑ Y	❑ N
Are you planning to get pregnant? (If you become pregnant, please inform your physician immediately)	❑ Y	❑ N
Are you on birth control pills?	❑ Y	❑ N

The above information is true and correct to the best of my belief.
Signature:_____
Date:_____