Cocheco Neurology

Kishori Somyreddy, MD

Date: _____

Name: _____ Birth Date: ____/____/_____ Age: _____ Sex: ____

Referring MD: _____ Primary MD: _____

Height: _____ Weight: _____ Marital Status: _____ Right/Left Handed: _____

Reason for Visit: _____

Medications:

Blood Thinners: Coumadin Plavix Aspirin Others: _____

Allergies: _____

Conditions (Please mark any conditions you have or had in the past):

- ☐ AIDS/HIV
- ☐ Alcohol Problem
- ☐ Appendicitis
- ☐ Arm Pain
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar Disorder
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Bronchitis
- ☐ Cancer
- ☐ Carpal Tunnel Snydrome
- ☐ Chemical Dependency
- ☐ Depression
- ☐ Diabetes
- ☐ Eating Disorder
- ☐ Epilepsy
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Gout
- ☐ Heart Disease
- ☐ Hernia
- ☐ High Cholesterol
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Back Pain
- ☐ Neck Pain
- ☐ Neuropathy
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Prostate Problem
- ☐ Psychiatric Care
- ☐ Sciatia
- ☐ Sexually Transmitted Disease
- ☐ Stroke/TIA
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers

Major ILLNESSES, SURGERIES, or HOSPITALIZATIONS (Please provide approximate year of illness/surgery):

_____

_____

_____

_____

_____

_____

Occupational Concerns:

Date of Injury: _____ Have you filed a work injury report with your employer? Y / N Is there a lawsuit planned relating to the current medical problem? Y / N

Occupation: _____

Health Habits:

Tobacco:	Yes	No	Packs per Day? _____
Alcohol:	Yes	No	Drinks per Day? _____
Recreational Drugs:	Yes	No	Please describe: _____

Family History:

Father: Age: _____ Condition of Health: _____

(if applicable) Deceased Age: _____ Cause of Death: _____

Mother: Age: _____ Condition of Health: _____

(if applicable) Deceased Age: _____ Cause of Death: _____

Any significant illnesses in the family:

_____

Constitutional Symptoms (mark any symptoms you may have):

GENERAL
- ☐ Fatigue
- ☐ Fever
- ☐ Loss of appetite
- ☐ Significant weight loss
- ☐ Significant weight gain

DERMATOLOGY
- ☐ Itching
- ☐ Redness
- ☐ Lumps
- ☐ Rash

ENDOCRINOLOGY
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Lactation

PSYCHOLOGY
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep Disturbances
- ☐ Hyperactivity
- ☐ Attention Deficit

NEUROLOGY
- ☐ Headache
- ☐ Migraine
- ☐ Memory Problems
- ☐ Tremor
- ☐ Balance Difficulty
- ☐ Numbness
- ☐ Weakness
- ☐ Speech Problems
- ☐ Dizziness
- ☐ Seizures

ENT/RESPIRATORY
- ☐ Hearing Loss
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Sleep Apnea
- ☐ Cough
- ☐ Change in voice
- ☐ Difficulty swallowing

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint Stiffness
- ☐ Muscle aches

CARDIOLOGY
- ☐ Chest pain
- ☐ Palpitations
- ☐ Leg swelling

HEMATOLOGY
- ☐ History of transfusion
- ☐ Easy bruising

GASTROENTEROLOGY
- ☐ Abdominal Pain
- ☐ Heart burn
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool

OPHTHALMOLOGY
- ☐ Vision Loss
- ☐ Blurring of vision
- ☐ Double vision

GENITOURINARY
- ☐ Difficulty urinating
- ☐ Urinary Urgency
- ☐ Increased urinary frequency
- ☐ Urinary incontinence

Notes: _____

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_____
_____
_____
_____
_____
_____
_____
_____

Please list the physicians to whom you would like for us to send a report:

- _____
- _____
- _____
- _____