



BURLINGTON NEUROLOGY & SLEEP CLINIC, PLC

TREATMENT OF:

- Neurology
- Dementia
- Epilepsy
- Headaches
- Multiple Sclerosis
- Parkinson's Disease
- Sleep Disorders

New Patient Intake Form

Dict Done: _____

Anil Dhuna, M.D., F.A.A.S.M.

Board Certified in
Neurology, Sleep Medicine,
Neurorehabilitation and
Clinical Neurophysiology

Date: _____

Patient ID: _____

Luanne Johnson, FNP-C

Certified Nurse Practitioner

Name: _____ DOB: _____ Age: _____

Katie Reuter, C-NP

Certified Nurse Practitioner

PROCEDURES

PERFORMED:

- EMG & NCV
- EEG & Video EEG
- Botox Injection
- Interventional Pain Procedures
- Independent Medical Exams
- Sleep Studies
- Vagal Nerve Stimulator (VNS)

Height: _____ Weight: _____ Blood pressure: _____ Pulse: _____

Handedness: Right _____ Left _____ Ambidextrous _____

Primary Care Physician: _____ Date symptoms began: _____

Main reason for your visit: _____

Describe briefly your present symptoms (problems): _____

Previous treatment for this problem (include therapy, surgery and medications)

Date of most recent blood test: _____ Where? _____

Recent X-rays/MRI/CT (circle): When? _____ Where? _____

Have you had an influenza vaccine in the past 12 months? ___ Yes ___ No

MEDICATIONS:

Name of Drug	Dose	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies:

Drug	What reaction?
_____	_____
_____	_____
_____	_____

PAST MEDICAL HISTORY:

Do you have or have you had these medical conditions:

- | | |
|--|--|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Tremor |
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Autoimmune disease |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Osteoarthritis |
| <input type="checkbox"/> CHF | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Anxiety disorder |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Migraine/headache |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Stroke syndrome |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Polyneuropathy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Motion sickness |
| <input type="checkbox"/> GI Disorder | <input type="checkbox"/> Restless Legs |
| <input type="checkbox"/> Kidney disorder | <input type="checkbox"/> Obstructive sleep apnea |

Other: _____

PREVIOUS OPERATIONS:

- | | |
|--|--|
| <input type="checkbox"/> Carotid artery surgery | <input type="checkbox"/> Hysterectomy |
| <input type="checkbox"/> Heart Valve replacement | <input type="checkbox"/> Appendectomy |
| <input type="checkbox"/> Carpal tunnel release | <input type="checkbox"/> Back Surgery |
| <input type="checkbox"/> Knee replacement | <input type="checkbox"/> Brain surgery |
| <input type="checkbox"/> Hip Replacement | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Gall bladder removal | <input type="checkbox"/> Pacemaker |

Other surgery:

SOCIAL HISTORY:

Marital status: (circle) Never married Married Divorced Separated Widowed

Do you smoke? (circle) yes no

How much? _____ cigarettes/ packs a day(circle one)

Given counsel to abstain? (circle) yes no.

How much alcohol do you drink? _____ per day _____ per month

Illicit drug use (circle): yes no.

If yes, what and how often: _____

Occupation: _____

Do you live alone? (circle) yes no.

If no, with who and what is their relationship to you? _____

FAMILY HISTORY:

Mother - 1 Father - 2 Brother - 3 Sister - 4

Please note with the above numbers if a member of your family has been diagnosed with:

Coronary artery disease	1 2 3 4	Migraine/headache	1 2 3 4
Congestive heart failure	1 2 3 4	Epilepsy	1 2 3 4
Hypertension	1 2 3 4	Stroke Syndrome	1 2 3 4
High cholesterol	1 2 3 4	Dementia	1 2 3 4
Diabetes	1 2 3 4	Parkinson's Disease	1 2 3 4
COPD	1 2 3 4	Restless leg syndrome	1 2 3 4
Cancer	1 2 3 4	Obstructive sleep apnea	1 2 3 4
Depression	1 2 3 4	Tremor	1 2 3 4

Patient Number _____

REVIEW OF SYSTEMS: (CURRENT COMPLAINTS)

Systemic Symptoms <input type="checkbox"/> Weight Change <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Night Sweats <input type="checkbox"/> Other constitutional	Pulmonary Symptoms <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Night sweats <input type="checkbox"/> Wheezing
HEENT Symptoms <input type="checkbox"/> Headache <input type="checkbox"/> Eyesight problems <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Other head-related symptoms	Cardiovascular Symptoms <input type="checkbox"/> Chest pain or discomfort <input type="checkbox"/> Fast heart rate <input type="checkbox"/> Palpitations <input type="checkbox"/> Other cardiovascular symptoms
Neck Symptoms <input type="checkbox"/> Neck pain <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Lump or swelling in the neck <input type="checkbox"/> Other neck symptoms	Gastrointestinal Symptoms <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Diarrhea
Genitourinary Symptoms <input type="checkbox"/> Blood in urine <input type="checkbox"/> Difficulty/pain with urination <input type="checkbox"/> Increased urinary frequency	Hematological Symptoms <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising
Skin Symptoms <input type="checkbox"/> Itching <input type="checkbox"/> Skin lesions <input type="checkbox"/> Rashes <input type="checkbox"/> Other skin symptoms	Psychological Symptoms <input type="checkbox"/> Sleep disturbance <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety
Other symptoms: <hr/> <hr/>	Endocrine Symptoms <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Other