WCCHS
Wyoming County Community Health System

Review of Systems

Please complete the following form and give it to your health care provider.

Info provided by: _____

Allergies: _____

Please check the following symptoms you have experienced in the past few weeks.

	Y	N		Y	N		Y	N
General			**Cardiovascular**			**Endocrine**		
Chills/Night sweats			Chest pain			Dry mouth/eyes		
Lethargy			Irregular heart rate			Excessive thirst/hunger		
Poor energy			Heart murmur			**Muscle/Bone**		
Weight loss			High blood pressure			Neck pain		
Fever			Swollen feet/ankles			Back Pain		
Neurological			**Respiratory**			Joint Pain		
Stroke			Cough			Muscle pain		
Seizure			Wheezing			Cramping		
Loss of consciousness			Shortness of breath			**Psychosocial**		
Memory changes			**Gastrointestinal**			Depression		
Weakness			Nausea			Anxiety		
Numbness/Tingling			Vomiting			Hallucinations		
Concussion			Heartburn			Difficulty sleeping		
Dizziness			Abdominal pain			Drug or alcohol abuse		
Loss of balance			Diarrhea			Considering suicide		
Falls			Constipation			Loss of sleep		
Tremor			Blood in stool			**Blood**		
Head and Eyes			Black/tarry stool			Anemia		
Headache			**Urinary**			Easy or frequent bruising		
Lightheadedness			Incontinence			Frequent nose bleeds		
Vision Loss			Difficulty urinating			Difficulty stopping bleed		
Double vision			Blood in urine			**Sleep**		
Blurry vision			Kidney stones			Sleep walking		
Vision changes			Frequent urination			Difficulty sleeping		
Drooping eyelid			Waking at night to urinate			Snoring		
Ear, Nose, and Throat			**Skin**			Daytime drowsiness		
Hearing loss			Rashes			Acting out dreams		
Ringing in your ears			Itchy/dry skin			**Sexual**		
Hoarse voice			Moles/birthmarks			Sexually active		
Difficulty chewing			Changes in color/texture			Change in period		
Difficulty swallowing			Hair loss					

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Neurology, Concussion, and Headache Center at WCCHS
New Patient Questionnaire

Date:	**Person filling out form:**

Patient Information

Last Name:	Middle:	First:	Marital Status: Single/Married/Divorced/Widow
Street Address		Birth Date:	Sex: M F
City:	State:	Zip Code:	Race:	Language:
Cell Phone: Home Phone:		Email:	Preferred means of contact: ☐ Phone ☐ Email
Primary Care Provider:		Referring Provider:	
Employment Status: ☐ Full Time ☐ Retired ☐ Part Time ☐ Not employed	Occupation:	Employer:	
Pharmacy Name:	Pharmacy Address:	Pharmacy Phone Number:	

Emergency Contact

Name:	Relationship to patient:	Phone Number:

Insurance Information

Primary Insurance Plan	Policy Number:	Group Number:
Name of Policy Holder:	Relationship to Patient:	
Secondary Insurance Plan	Policy Number:	Group Number:
Name of Policy Holder:	Relationship to Patient:	

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What symptoms or neurological disorder are you being evaluated for?	
Have you seen another neurologist for this problem, and if so, who?	
What testing have you had done to evaluate this problem and where were they completed? (CT, MRI, labs, EMG, etc)	

Medical and Surgical history

Past medical history
Please list any medical problems you have or are currently being treated for

Past Surgical History
Please list any surgeries you have had in the past and year the surgery was performed

Allergies:
Please list allergies and reaction you have had

Social History:

Do you currently smoke or use tobacco products?	☐ No ☐ Yes What type and how much?
Have you ever smoked?	☐ No ☐ Yes Quit date:
Do you drink alcohol?	☐ No ☐ Yes If yes, what kind? How many drinks per week?
Highest level of education completed?	