BRIGHAM AND WOMEN'S HOSPITAL
Specializing in care for a lifetime

HARVARD MEDICAL SCHOOL
TEACHING AFFILIATE

Welcome to the BWH Department of Neurology

Who referred you to us? (name/address - *if changed*): _____

_____

Other physicians, including your neurologist, who should receive correspondence regarding your care:

[1] Name: _____ [2] Name: _____

Address: _____ Address : _____

_____ _____

Phone: _____ Phone: _____

Diagnosis: _____

New Problems: _____

_____

_____

Tests completed since last visit: _____

_____

_____

LIST CURRENT MEDICATIONS:

Drug Name	Dose	Frequency	Refills Needed?

REVIEW OF SYSTEMS:	*YES NO*		*YES NO*
Neurological System		**Cardiac System**	
Do you have a headache?	☐ ☐	Do you have chest pains?	☐ ☐
Do your headaches wake you up at night?	☐ ☐	Do you have palpitations?	☐ ☐
Do you have seizures?	☐ ☐		
Have you ever lost consciousness for other reasons?	☐ ☐	**Gastrointestinal System**	
Do you have weakness?	☐ ☐	Have you lost your appetite?	☐ ☐
Do you have numbness?	☐ ☐	Have you lost weight unexpectedly?	☐ ☐
Do you have dizziness?	☐ ☐	Do you have indigestion or heartburn?	☐ ☐
Do you have double vision?	☐ ☐	Do you have stomach pains?	☐ ☐
Do you have blurred vision?	☐ ☐	Do you have constipation or diarrhea?	☐ ☐
Do you have confusion?	☐ ☐	Do you have nausea or vomiting?	☐ ☐
Do you have memory loss?	☐ ☐		
Do you have trouble walking?	☐ ☐	**Urinary System**	
Can you take care of yourself?	☐ ☐	Do you have burning while urinating?	☐ ☐
Do you fall?	☐ ☐	Do you have blood in your urine?	☐ ☐
		Do you wake up at night to urinate?	☐ ☐
Mental Health		Do you have to rush to urinate?	☐ ☐
Do you feel depressed?	☐ ☐	Do you lose control of urination or your stool?	☐ ☐
Do you have sleeping problems?	☐ ☐		
Do you feel anxious?	☐ ☐	**Musculoskeletal System**	
		Do you have neck pain?	☐ ☐
Respiratory System		Do you have back pain?	☐ ☐
Do you have a cough?	☐ ☐	Do you have joint pains?	
Do you cough up thick mucus?	☐ ☐	Where? _____	
Have you coughed up blood?	☐ ☐		
Do you have shortness of breath?	☐ ☐	**General**	
		Do you have fevers?	☐ ☐
Skin		Do you have night sweats?	☐ ☐
Do you have a rash?	☐ ☐	Do you have fatigue?	☐ ☐

Date:_____Time: _____Patient Signature:_____

Date:_____Time:_____Physician Signature:_____Clinic ID#_____