Desert Neurology

Do you have any of the following symptoms? Please check all that apply.

□ Dizziness
□ Headaches
□ Numbness/Tingling
□ Memory Loss
□ Seizures
□ Muscle Weakness
□ Pain? Where? _____
□ Gait Issues
□ Tremors
□ Neck Pain
□ Back Pain

Past Medical History

□ Kidney Disease
□ Cancer: _____
□ Diabetes
□ Parkinson's Disease
□ Cardiovascular Disease
□ High Blood Pressure
□ Stroke/TIA
□ High Cholesterol
□ Multiple Sclerosis

OTHERS: _____
_____

Recent Hospitalizations

Hospital Name/Date of Hospitalization: _____

LIST OF MEDICATIONS, INCLUDING OVER THE COUNTER DRUGS, VITAMINS, SUPPLEMENTS AND THEIR USE:

MEDICATION NAME	**DOSE/STRENGTH**	**FREQUENCY**	**REASON**
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____
8. _____	_____	_____	_____

ALLERGIES

□ NO KNOWN □ CODIENE □ PENICILLIN □ IODINE □ SULFA □ DEMEROL