THE NEUROLOGICAL INSTITUTE & SPECIALTY CENTERS
521 E. 86th Avenue, Suite Z
Merrillville, IN 46410
(219) 769-0777

Patient name: ______________________________ Date: ____________________
Date of birth: ____________ Age: ________ Collar/neck size: __________ inches Pregnant: Yes _____ No
Referring Physician: ____________________ Primary Care Physician: ____________________

Patient's Main Complaint: ____
____
____

Previous Accidents/Injuries ____

MEDICAL HISTORY

Condition	Yes	No	Date of Diagnosis
Allergies/Hayfever	Yes	No	________
Alzheimer's disease	Yes	No	________
Anemia	Yes	No	________
Arthritis	Yes	No	________
Benign prostatic hypertrophy	Yes	No	________
Cancer	Yes	No	________
Cataracts	Yes	No	________
Celiac Disease	Yes	No	________
Diabetes	Yes	No	________
Elevated cholesterol	Yes	No	________
Elevated triglycerides	Yes	No	________
Glaucoma	Yes	No	________
Heart arrhythmia	Yes	No	________
(Type if known ______________________)			
Heart disease	Yes	No	________
Head/Brain injury	Yes	No	________
High blood pressure	Yes	No	________
Kidney disease	Yes	No	________
Kidney stones	Yes	No	________
Liver disease	Yes	No	________
Lung disease/asthma	Yes	No	________
Macular degeneration	Yes	No	________
Meningitis/encephalitis	Yes	No	________
Multiple sclerosis	Yes	No	________
Osteoporosis/Osteopenia	Yes	No	________
Parkinson's disease	Yes	No	________
Seizures/epilepsy	Yes	No	________
Sinus disease	Yes	No	________
Stroke	Yes	No	________
Thyroid disease	Yes	No	________
Tuberculosis	Yes	No	________
Unusual travel	Yes	No	________
Toxic exposure	Yes	No	________
Exotic animal exposure	Yes	No	________

PAST HOSPITALIZATIONS AND SURGERIES

Description	Dates	Description	Dates
____________	________	____________	________

CURRENT MEDICATIONS (including over-the-counter)

Name	Dose	Name	Dose
____________	________	____________	________
____________	________	____________	________
____________	________	____________	________
____________	________	____________	________

Are you allergic to any foods or medications? Yes No If yes, please list and describe treatment: ____________
____

Do you or have you used any prescription or over-the-counter medications to help you sleep (i.e., Ambien, Benadryl, Tylenol PM, etc.)? Yes No If yes, please list: ______________________________

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REVIEW OF SYSTEMS

Do you or have you had any of the following symptoms:

Symptom			Symptom			Symptom		
Lack of energy	Yes	No	Blackouts or fainting	Yes	No	Depression	Yes	No
Nausea	Yes	No	Shortness of breath	Yes	No	Difficulty thinking	Yes	No
Vomiting	Yes	No	Chest pain	Yes	No	Memory loss	Yes	No
Double vision	Yes	No	Coughing	Yes	No	Behavior change	Yes	No
Blurred vision	Yes	No	Joint pain	Yes	No	Visual hallucinations	Yes	No
Loss of vision	Yes	No	Palpitations	Yes	No	Frequent infection	Yes	No
Weakness	Yes	No	Swelling of legs	Yes	No	Abdominal pain	Yes	No
Numbness/tingling in limbs	Yes	No	Difficulty walking	Yes	No	Difficulty with		
Pain in leg(s)	Yes	No	Falls	Yes	No	bowel/bladder	Yes	No
Tremors or shaking	Yes	No	Dizziness	Yes	No	Bloody/black stool	Yes	No
Convulsions	Yes	No	Balance Problems	Yes	No	Bloody urine	Yes	No
Head injury	Yes	No	Poor coordination	Yes	No	Weight loss	Yes	No
Hearing difficulty	Yes	No	Back or neck pain	Yes	No	Menstrual difficulty	Yes	No
Ringing in the ears	Yes	No	Swallowing difficulty	Yes	No			
Change in smell	Yes	No	Speech difficulty	Yes	No			
Change in taste	Yes	No	Circulation problems	Yes	No			

If you answer yes to any of the following, please also complete the form entitled "Sleep Questionnaire."

Insomnia	Yes	No
Snoring	Yes	No
Excessive daytime sleepiness	Yes	No

If you answer yes to the following, please also complete the form entitled "Headache Questionnaire."

Headache	Yes	No
Neck pain	Yes	No
Face pain	Yes	No

THE EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation:

0 = would never doze
1 = slight chance of dozing
2 = moderate chance of dozing
3 = high chance of dozing

Situations:

Sitting and reading	___________
Sitting inactive in a public place (i.e., a theater or meeting)	___________
As a passenger in a car for an hour without a break	___________
Lying down to rest in the afternoon when circumstances permit	___________
Sitting and talking to someone	___________
Sitting quietly after a lunch without alcohol	___________
In a car, while stopped, for a few minutes in the traffic	___________
Watching t.v.	___________
TOTAL:	___________

Note: If your score is 10 or more, please also complete the attached form entitled "Sleep Questionnaire."

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SOCIAL HISTORY

Occupation: ___________________________ Shift Work: Yes No Retired Yes No Date: __________

Marital status: Single Married Widowed Divorced Other

Do you have children? Yes No If yes, how many?

On average, how much alcohol do you drink per day?
(If less than 1 drink per day , enter 0)

______ Cans of beer
______ Ounces of liquor
______ Glasses of wine (4 oz/glass)

On average, how much of the following caffeine products do you drink in a day?
(If less than 1 drink per day, enter 0)

______ Cups of coffee
______ Cups of tea
______ Cans of soda (i.e., Pepsi, Coke Dr. Pepper, Mountain Dew, etc.)

Do you presently smoke cigarettes? Yes No Packs per day __________

Did you smoke in the past? Yes No Date quit ___________

Have you, do you, use marijuana? Yes No How much? ___________

Have you, do you, use cocaine? Yes No How much? ___________

Have you, do you, use illicit IV drugs? Yes No How much? ___________

FAMILY HISTORY

Do you have any siblings? Yes No Number of: _______ Brothers ________ Sisters

Has any of your blood (immediate) family suffered from:

Snoring	Yes	No	Epilepsy	Yes	No
Sleep apnea	Yes	No	Cancer	Yes	No
Insomnia	Yes	No	Multiple Sclerosis	Yes	No
Excessive daytime sleepiness/Narcolepsy	Yes	No	Alzheimer's disease	Yes	No
Restless leg syndrome	Yes	No	Memory loss	Yes	No
Periodic limb movement disorder	Yes	No	Parkinson's disease	Yes	No
Other sleep disorders____________________________			Huntington's disease	Yes	No
Aneurysm	Yes	No	Migraine	Yes	No
Heart disease	Yes	No	Osteoporosis	Yes	No
High blood pressure	Yes	No	Diabetes	Yes	No
Stroke	Yes	No			

NOTE: PLEASE REMEMBER TO FILL OUT ANY APPROPRIATE FORMS FOR SLEEP AND/OR HEADACHE.

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