THE Portland Clinic®

Department of Neurology
New Patient Form

FIRST NAME: _____ **LAST NAME:** _____

DATE OF BIRTH: _____ **PRIMARY CARE PROVIDER & CLINIC:** _____

PREVIOUS NEUROLOGIST: _____

I. REASON FOR VISIT - CHIEF COMPLAINT (HISTORY OF PRESENT ILLNESS)

Please describe the concern or problem that brings you in today:

_____

_____

Is this visit related to worker's compensation? *(circle one)* Yes No

Is this visit related to any legal actions? *(circle one)* Yes No

If this problem is the result of an accident, when did the accident occur? _____

Do you have any questions for your doctor?

_____

_____

_____

II. PAIN ASSESSMENT

Do you experience pain as part of your daily life? *(circle one)* Yes No

If yes, please describe the location(s), onset, duration, and characteristics of your pain:

_____

_____

_____

If yes, on a scale of 1 to 10 (0 = no pain, 10 = the worst pain), how would you rate your pain? _____

Neurology Locations
[11006 8/14]

The Portland Clinic - South
6640 SW Redwood Lane
Portland, OR 97224
(503) 620-7358

The Portland Clinic - Downtown
800 SW 13th Ave
Portland, OR 97205
(503) 221-0161

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III. HISTORY OF FALLS

Have you had any significant falls in the past 6 months? Yes No

If yes, please explain: _____

IV. HANDEDNESS

Are you *(circle one)*: Left Handed Right Handed

V. FAMILY HISTORY Do you have a family member affected with:

Condition	Yes	No	Type/affected relative	Condition	Yes	No	Type/affected relative
Brain Tumor	☐	☐		Muscle Disease	☐	☐	
Seizures or epilepsy	☐	☐		Neuropathy	☐	☐	
Dementia	☐	☐		Other Neurological Disorder	☐	☐	
Parkinson's	☐	☐		Hypertension	☐	☐	
Multiple Sclerosis	☐	☐		Diabetes	☐	☐	
Thyroid Disease	☐	☐		Migraines	☐	☐	

Write other conditions: _____

_____

_____

VI. MEDICATION HISTORY

Please list all **MEDICATIONS** you take routinely, prescribed or over-the-counter, along with the dosages:
(If you are a Portland Clinic patient and our list is up to date leave blank)

Medication:	Dose:	Frequency:

Please list all allergies and sensitivities (e.g. medications, foods, latex, iodine, etc.)

_____

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VII. PAST MEDICAL HISTORY:

Have you had or do you have any of the following conditions?

	Yes	No
Alcoholism	☐	☐
Arthritis	☐	☐
Asthma	☐	☐
Cancer	☐	☐
Chest Pain	☐	☐
Colitis	☐	☐
Depression / Anxiety	☐	☐
Diabetes	☐	☐
Drug Addiction	☐	☐
Emphysema	☐	☐
Frequent Kidney Infections	☐	☐
Frequent Bladder Infections	☐	☐
Gallbladder disease	☐	☐
Gout	☐	☐

	Yes	No
High Blood Pressure	☐	☐
Headache	☐	☐
Hepatitis	☐	☐
Heart Attack	☐	☐
Jaundice	☐	☐
Kidney Disease	☐	☐
Other Heart Disease	☐	☐
Pain (Chronic)	☐	☐
Rheumatic Fever	☐	☐
Stomach Ulcers	☐	☐
Thyroid Disease	☐	☐
Trouble Sleeping	☐	☐
Suicidal Thoughts	☐	☐

Other _____

_____

_____

VIII. SURGERIES:

(List procedure and approximate year)

Procedure	Year	Procedure	Year

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IX. PERSONAL HABITS:

Do you drink alcohol? Yes ____ No ____

If yes: Regularly ____ Socially ____

Hard liquor ☐ 1-3 oz per day ____ over 3 oz per day ____

Beer ☐ 1 bottle/can per day ____ 2 bottles/cans per day ____ 3 or more bottles/cans per day ____

Wine ☐ 1-2 glasses per day ____ 3-5 glasses per day ____ more than 5 glasses per day ____

Do you consume more than 5 drinks within a 24 hour period? Yes ____ No ____

How many days in the last 6 months did you consume more than 5 drinks in a 24 hour period? _____

Do you smoke? Yes ____ No ____

Have you smoked in the past? Yes ____ No ____

Do you or have you used recreational / illicit drugs? Yes ____ No ____

If yes, what have you used?_____

_____

When did you last use above substance?_____

Do you drink caffeinated drinks? Yes ____ No ____

If yes, list how many per day of the following: _____ Coffee; _____ Tea; _____ Soda; _____ Energy Drinks

X. CURRENT SYMPTOMS IN THE LAST 6 MONTHS: (please mark all that apply)

1. Head, Eyes, Ears, Nose, Throat, Lymph Nodes:

- ___ Headaches
- ___ Double vision
- ___ Hoarseness of voice
- ___ Tinnitus (buzzing or humming)
- ___ Photophobia (light bothers eyes)
- ___ Swollen and/or painful lymph nodes
- ___ Head trauma
- ___ Deafness
- ___ Neck swelling
- ___ Pain and/or drainage from ears
- ___ Nasal and/or sinus congestion
- ___ Visual loss or change
- ___ Nose bleeds
- ___ Neck stiffness
- ___ Sneezing
- ___ Sore throat
- ___ Glaucoma
- ___ Teethe grinding / clenching
- ___ Headaches
- ___ Hearing problems
- ___ Vision problems
- ___ Dental problems
- ___ Sinus problems

Current Symptoms Continued on Next Page >>

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2. Respiratory System:

- ___ Shortness of breath
- ___ Sputum/secretion production
- ___ Wheezing
- ___ Cough
- ___ Hemoptysis
- ___ Breathing difficulty

3. Cardiovascular System:

- ___ Chest pain, discomfort, heaviness, tightness
- ___ Shortness of breath with exertion
- ___ PND (waking up short of breath)
- ___ Orthopnea (sleeping on two or more pillows)
- ___ Leg swelling
- ___ High blood pressure
- ___ Palpitations
- ___ Chest pain
- ___ Heartburn

4. Gastrointestinal System:

- ___ Anorexia (poor appetite)
- ___ Nausea and/or vomiting
- ___ Constipation or diarrhea
- ___ Weight loss or gain
- ___ Hematochezia (red blood in bowel movements)
- ___ Melena (black bowel movements)
- ___ Jaundice
- ___ Abdominal pain
- ___ Dysphagia (difficulty swollowing)
- ___ Stomach pain
- ___ Weight change: loss _____ lbs , gain_____lbs

5. Genitourinary System:

- ___ Hematuria
- ___ Oliguria (infrequent urination)
- ___ Incontinence
- ___ Heavy menstrual flow
- ___ Polyuria (urination of large volumes of urnie)
- ___ Nocturia (urination at night)
- ___ Frequency (frequent urination)
- ___ Pyuria (cloudy urine)
- ___ Urgency (sensation to urinate)
- ___ Sexual dysfunction
- ___ Symptoms of menopause
- ___ Irregular periods
- ___ PMS
- ___ Bladder problems
- ___ Excessive urination or thirst

6. Nervous system:

- ___ Weakness/paralysis one side of body
- ___ Urinary and/or fecal incontinence (wet or soil underwear)
- ___ Memory loss, sleep disturbance, mood disorders (anxiety, depression)
- ___ Insomnia
- ___ Daytime sleepiness
- ___ Snoring
- ___ Sleep apnea
- ___ Seizures / shaking
- ___ Numbness
- ___ Loss of consciousness
- ___ Dizziness

7. Musculoskeletal System:

- ___ Joint pain / swelling / redness
- ___ Muscle aches and pains
- ___ Back pain
- ___ Neck pain
- ___ Leg / foot cramps
- ___ Leg restlessness
- ___ Weakness

8. Dermatological System:

- ___ Rash
- ___ Mole changes
- ___ Pigmentation (change in color)
- ___ Breast pain
- ___ Pruritus (itching)
- ___ Breast lumps
- ___ Bleeding or bruising
- ___ Changes in nipples
- ___ Breast lumps / discharge
- ___ Allergic reaction
- ___ Change in skin / hair

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