Neurological Associates
of Long Island, P.C.

Patients Name_____
Patient's Signature_____
Today's Date _____

Please answer all questions completely. Do not leave any blanks

Please describe the reason for your visit today: _____
Is your condition a result of a work related injury? Yes ___ or No____
Is your condition a result of a motor vehicle accident? Yes___ or No_____
Please list the medications you are currently taking including prescription medications, over the counter, herbal remedies and vitamins. Please include dosage and how often they are taken:

_____

_____

Do you have any allergies? Yes or No **If yes, please list**_____
Do you have diabetes? Yes or No **If yes, for how long**? _____
Do you have high blood pressure? Yes or No **If yes, for how long**? _____
Height: _____ft _____in Weight_____

Do you have: Pacemaker/Loop Recorder/Defibrillator? Yes or No **If yes, circle which one**

Have you had any falls in the past 12 months? Yes or No **If yes, How Many**? _____
Are you experiencing any pain? Yes or No **What is the intensity on a scale of 1-10?** _____
Please describe any problems/conditions you have or have had with:
Heart_____
Lungs_____
Kidneys/Prostate_____
Stomach/Bowels_____
Thyroid_____
Eyes_____
Ears_____
Immunologic_____
Psychiatric_____
Please describe any other medical problems you have or have had:

_____

Please list any operations or hospitalizations (with dates)

_____

Are you a tobacco user? Yes or No What Kind? _____ How much? _____
Do you drink alcohol/beer/wine? Yes or No How much? _____
Family Medical History: _____
Do You Have an Advanced Directive? Yes or No

Doctor's Signature: _____
Today's Date: _____

Please use back of form if additional space is needed

updated 7/11/2023