

Patricia Kavanagh, M.D.

Neurology • Movement Disorders

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I. Personal Information

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: Home _____ Office _____

Cell _____ Fax _____ Email _____

Age _____ Date of birth ____/____/____ Social Security # ____/____/____

Referred by _____

If you would like us to send our consultation note to another physician, provide information:

Name _____ Telephone (____) _____

Address _____

II. Insurance Information

Primary insurance _____ Telephone _____

Policy number _____ Group number _____

Insured _____ Date of birth ____/____/____ Relationship to patient _____

Secondary insurance _____ Telephone _____

Policy number _____ Group number _____

Insured _____ Date of birth ____/____/____ Relationship to patient _____

I understand that I am responsible for my bill.

____ I authorize the release of information to my insurance company(s).

____ I authorize payment directly to my doctor.

IV. Medical History

Note **current or former** medical diagnoses:

High blood pressure (hypertension) _____ Heart or circulation problems _____
High cholesterol _____ Diabetes _____
Substance abuse _____ Anemia or other blood disorder _____
Digestive problems _____ Lung disease _____
Head or neck trauma _____
Urologic problems (including impotence, prostate, bladder problems) _____
Infections (including pneumonia, meningitis, venereal disease, HIV) _____
Cancer (type and treatment) _____
Other _____

Trauma or accident (nature and approximate date):

Surgery (type and approximate date): _____

Hospitalizations (reason and approximate date): _____

Note **any** symptoms or functions which concern you:

Fatigue _____	Sleep _____	Pain _____
Appetite _____	Dizziness, vertigo, sense of spinning _____	Feelings of sadness or depression _____
Memory _____	Thinking ability _____	Reading _____
Writing _____	Doing complex tasks _____	Nightmares _____
Eyes playing tricks while awake _____	Vision _____	Loss or change of smell or taste _____

Swallowing _____

Speaking _____

Drooling _____

Constipation _____

Loss of sexual interest
or activity _____

Urinary frequency,
urgency or difficulty _____

Incontinence of
urine or stool _____

Weakness of
specific muscles _____

Numbness
or tingling _____

Clumsiness _____

Slow movements _____

Tremor _____

Involuntary
movements _____

Falls or
near falls _____

V. Family Medical History

If a sibling, parent, grandparent, aunt or uncle have or had any of these conditions, **check** the item:

Parkinson's disease _____

Dystonia _____

Torticollis _____

Tremor _____

Tics _____

Cerebral palsy _____

Scoliosis _____

Stuttering _____

Dementia _____

Alzheimer's _____

Stroke _____

Brain tumor _____

Multiple sclerosis _____

Migraine _____

Chronic
headache _____

Back pain _____

Seizures, epilepsy _____

Schizophrenia _____

Anxiety disorder _____

Major
depression _____

Sleep disorder _____

Alcohol or
drug abuse _____

Any other neurologic or psychiatric condition _____

VI. Personal Information

Occupation _____ Years of school or diploma/degree _____

Marital status _____ Spouse or partner's name _____

Age _____ Health _____ Occupation _____

Number of children and ages _____

Sports or regular activity _____ Height _____ Weight _____

Has your weight changed by more than 5 pounds in the past year? _____

Are you right-handed _____ or left-handed? _____

Smoking: Current _____ Former _____ Never _____

Beer, wine, or spirits: Current _____ Former _____ Never _____

Recreational drugs: Current _____ Former _____ Never _____

Exposure to pesticides, chemicals, radiation: Current _____ Former _____ Never _____

VII. Consultation (optional)

What are the **symptoms or problems** that bring you here for this consultation?

What **questions** do you have for the doctor? Use the back of this sheet if you need more space.

I would like to learn about research studies pertaining to my diagnosis _____ yes _____ no