MILLMAN NEUROLOGY

NEW PATIENT INTAKE

Today's Date: _____

Last Name_____First Name_____

Date of Birth: _____ Age:_____ SS# _____-_____-_____

Sex: ____Male ____Female Marital status: ___Single ___Married ___Divorced ___Widowed

Street Address: _____City_____Zip: _____

Telephone#: (Circle preferred) Cell _____ Home _____

Email address: _____

Pharmacy Name: _____ Street Address:_____City: _____

Pharmacy Phone: _____ Mail Order Pharmacy _____

Employer Name: _____ Occupation: _____

Street Address:_____ City: _____ Employer Phone: _____

Emergency Contact: _____ Tel#: _____ Relationship: _____

Primary Medical Doctor: _____

Street Address:_____ City: _____ Phone: _____

Referring Doctor (if not your primary doctor):_____

Street Address:_____ City: _____ Phone: _____

ALLERGIES: *Please list any medication allergies below or check if none.* ☐ No Known Drug Allergies

Medication Name	Allergic Reaction

MEDICATIONS: *Please list all prescribed medications and vitamins, or Provide us a list*

Medication Name	Strength/Dose (mg)	Number of Times per Day	Medication Name	Strength/Dose (mg)	Number of Times per Day

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Phone: 248-256-5000 Fax: 248-257-0482
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PAST MEDICAL HISTORY: (*Please check all that apply)*

☐ Anxiety
☐ Asthma
☐ AFIB/Atrial Fibrillation
☐ Bipolar Disease
☐ Bleeding Disorder
☐ Cancer, type _____
☐ COPD/Emphysema
☐ CAD/Heart disease
☐ Clotting Disorder
☐ Crohn's/Ulcerative Colitis
☐ Depression
☐ Diabetes
☐ Glaucoma
☐ High cholesterol
☐ High blood pressure
☐ Kidney stone(s)
☐ Kidney Disease
☐ Liver Disease
☐ Migraine headaches
☐ Osteoporosis/Osteopenia
☐ Psychiatric hospitalization
☐ Rheumatoid Arthritis
☐ Sleep Apnea
☐ Stroke
☐ SLE
☐ Thyroid disease
☐ Ulcers

Please list any others: _____

PAST SURGICAL HISTORY: (*Please check all that apply)*

☐ Aneurysm coiling
☐ Aneurysm clipping
☐ Brain surgery for _____
☐ Cervical fusion
☐ Lumbar discectomy
☐ Lumbar laminectomy
☐ Lumbar fusion
☐ Pacemaker
☐ Defibrillator
☐ Cardiac stent(s)
☐ Coronary artery bypass graft
☐ Heart valve replacement
□ Bovine □ Pig □ Metal
☐ Carotid artery ___Right or ___Left
☐ Gallbladder
☐ Appendix
☐ Inguinal hernia ___Right or ___Left
☐ Prostate
☐ Hysterectomy
☐ C-section
☐ Shoulder surgery ___Right or ___Left
☐ Elbow surgery ___Right or ___Left
☐ Carpal tunnel ___Right or ___Left
☐ Knee surgery ___Right or ___Left
☐ Knee replacement ___Right or ___Left
☐ Hip replacement ___Right or ___Left

Please list others: _____

FAMILY HISTORY: (*Please check all that apply)*

	Father	Mother	Brother	Sister	Son	Daughter	Paternal Grandfather	Paternal Grandmother	Maternal Grandfather	Maternal Grandmthr
Cerebral aneurysm										
Dementia										
Epilepsy										
Migraine										
Parkinson's Disease										
Stroke										
Tremor										

SOCIAL HISTORY:

Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed How many children? _____

Live with: ☐ Spouse ☐ Partner ☐ Alone ☐ Children ☐ Parent(s) ☐ Sibling(s) ☐Other _____

Occupation: _____ ☐ Retired

Tobacco Use: ☐ Regularly packs/day_____ ☐ Occasional ☐ Never ☐ Previously, quit when?_____

Alcohol Use: ☐ None ☐ Rarely ☐ Socially ☐ Occasionally ☐ Often ☐ Daily ☐ Regularly in the past
current drinks/day_____

Illicit drug use: ☐ None ☐ Rarely ☐ Socially ☐ Occasionally ☐ Often ☐ Daily ☐ Regularly in the past
Which drug(s)? _____

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