CSNA
Colorado Springs Neurological Associates
Comprehensive Neurosciences

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Date: ___/___/___
Name: _____ Age: _____ Date of Birth: ___/___/___ Sex: M / F
Referring MD: _____ Primary MD: _____ Height: ____ Weight: ____ Right / Left Handed
How did you hear about us? ☐ Online ☐Physician Referral ☐ Friend/relative ☐ Other: _____
Please list conditions / diseases you wish to have checked at this examination:
_____
_____

MEDICATIONS: (Please list medications & dosages)	

ANY BLOOD THINNERS: Coumadin Plavix Aspirin Other:_____
ALLERGIES: (Please list any allergies to medications) _____

CONDITIONS: (Please mark any conditions you have or had in the past)

☐ AIDS / HIV	☐ Bronchitis	☐ Emphysema	☐ Liver Disease	☐ Rheumatoid Arthritis
☐ Alcohol problems	☐ Cancer	☐ Fibromyalgia	☐ Low back pain	☐ Sciatica
☐ Appendicitis	☐ Carpal Tunnel Syndrome	☐ Gout	☐ Neck pain	☐ Sexually Transmitted Disease
☐ Arm pain	☐ Chemical Dependency	☐ Heart Disease	☐ Neuropathy	☐ Stroke / TIA
☐ Asthma	☐ Depression	☐ Hernia	☐ Osteoporosis	☐ Suicide attempt
☐ Bipolar Disorder	☐ Diabetes	☐ High Cholesterol	☐ Pneumonia	☐ Thyroid problems
☐ Bleeding Disorders	☐ Eating Disorder	☐ High Blood Pressure	☐ Prostate problem	☐ Tuberculosis
☐ Breast lump	☐ Epilepsy	☐ Kidney Disease	☐ Psychiatric Care	☐ Ulcers

MAJOR ILLNESSES, SURGERIES, or HOSPITALIZATIONS:
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____
_____ Year: _____

OCCUPATIONAL CONCERNS:
Have you filed a Work Injury report with your employer?
YES / NO
Date of injury: ___/___/___

Is there a lawsuit planned that relates to the current medical problem?
YES / NO

Your occupation: _____ Marital Status: _____

HEALTH HABITS
Tobacco Yes / No Packs per day: _____
Alcohol Yes / No Drinks per day: _____
Recreational Drugs Yes / No

FAMILY HISTORY
Father – Age: ___ Condition of health: _____ Deceased at age: ___ Cause of death: _____
Mother – Age: ___ Condition of health: _____ Deceased at age: ___ Cause of death: _____
Any significant illnesses in the family: _____

Constitutional Symptoms: (Please mark any symptoms that you may have)

GENERAL
- ☐ Fever
- ☐ Fatigue
- ☐ Loss of appetite
- ☐ Significant weight loss

OPHTHALMOLOGY
- ☐ Vision loss
- ☐ Blurring of vision
- ☐ Double vision

GASTROENTEROLOGY
- ☐ Abdominal pain
- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Blood in stool

DERMATOLOGY
- ☐ Itching
- ☐ Redness
- ☐ Lumps
- ☐ Rash
- ☐ Skin cancer

HEMATOLOGY
- ☐ History of transfusion
- ☐ Easy bruising

MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Muscle aches

ENT / RESPIRATORY
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Shortness of breath
- ☐ Sleep apnea
- ☐ Cold and cough
- ☐ Change in voice
- ☐ Difficulty swallowing

PSYCHOLOGY
- ☐ Anxiety
- ☐ Depression
- ☐ Sleep disturbances
- ☐ Hyperactivity
- ☐ Attention deficit

ENDOCRINOLOGY
- ☐ Excessive sweating
- ☐ Excessive thirst
- ☐ Temperature intolerance
- ☐ Lactation

NEUROLOGY
- ☐ Headache
- ☐ Memory problems
- ☐ Tremors
- ☐ Balance difficulty
- ☐ Numbness
- ☐ Weakness
- ☐ Speech problems
- ☐ Dizziness
- ☐ Seizures

CARDIOLOGY
- ☐ Chest pain
- ☐ Palpitations / irregular heartbeat
- ☐ Leg swelling
- ☐ History of heart attack
- ☐ Atrial fibrillation

GENITOURINARY
- ☐ Difficulty urinating
- ☐ Urinary urgency
- ☐ Increased urinary frequency
- ☐ Urinary incontinence

NOTES:

_____

_____

_____

_____

_____

_____

Please list the physicians to whom you would like for us to send a report:

- _____
- _____
- _____
- _____

Patient signature: _____